DHCFP

Massachusetts Health Care Cost Trends
Final Report

Appendices C.5a – C.5f:
Transcripts for March 16, March 18, and March 19, 2010

April 2010

Deval L. Patrick, Governor
Commonwealth of Massachusetts

Timothy P. Murray
Lieutenant Governor

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Executive Office of Health and Human Services

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Division of Health Care Finance and Policy

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Massachusetts Health Care Cost Trends Final Report

Appendix C.5a

Health Care Cost Trends Public Hearings

Transcript for Morning Session Tuesday, March 16, 2010

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COMMONWEALTH OF MASSACHUSETTS

Executive Office of Health and Human Services
Division of Health Care Finance and Policy

PUBLIC HEARING RE:

HEALTH CARE PROVIDER AND PAYER COSTS TRENDS

BEFORE: David Morales, Commissioner

Held at:

University of Massachusetts Boston
Joseph P. Healey Library
100 Morrissey Boulevard
Boston, Massachusetts 02125

Tuesday, March 16, 2010
9:12 a.m.

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I N D E X

P R O C E E D I N G S

COMMISSIONER DAVID MORALES: Good morning and welcome.

FROM THE AUDIENCE: Good morning.

COMMISSIONER DAVID MORALES: Thank you, good morning.

I am joined today by three key partners here; Tom O'Brien, Assistant Attorney General; Commissioner Murphy and soon Commissioner John Auerbach for the Department of Public Health.

Again I want to thank you all for coming. My name is David Morales, Commissioner of Health Care Finance and Policy.

I welcome you to the opening day of the Division's public hearings on Health Care Cost Trends.

Before we get started though, I want to take sometime to provide an overview of our goals for the hearings and to explain our general format today.

In 2006 when Massachusetts passed

its landmark Health Reform Law it set a model for the nation of designing a path to achieve near universal health insurance coverage.

While the effort to expand coverage has proven successful with over 97 percent of the state's residents now insured, the rapid growth of health care costs both locally and across the nation continues to cause significant challenges.

Individuals, families, communities and employers are still struggling under the weight of higher health care costs which cut into wage growth, stymy job creation and impact spending on other sectors of the economy at precisely the time we need to rebuild our economy.

In fact, the cost of health insurance has grown by approximately 7 and-a-half percent each year on average over the last decade while gross domestic product has only increased about 3 and-a-half percent per year during that same period.

In the same sense that there was a

shared responsibility for expansion in coverage in Massachusetts we must now focus our collective attention to mitigating health care costs and maximizing quality and efficiency in our health care system.

There is no easy answer or solution to this challenge.

These hearings represent a critical juncture for the Massachusetts health care system and for the Commonwealth in general.

In 2008 the legislature passed a law led by Senate President Murray that directed the Division to issue reports on health care costs and to then hold public hearings with key stakeholders on the health care system to help determine the best course forward with action-oriented solutions.

These hearings are the culmination of over a year's work researching health care cost growth in the Commonwealth by the Division of Health Care Finance and Policy, the Office of the Attorney General, the Division of Insurance and many others across government and the marketplace.

We are committed to developing a more rationale and effective approach to insuring our health care system delivers value, mitigates health care cost and provides quality care.

This week's hearings bring together key health care stakeholders -- providers, insurers, employers and consumers and experts.

In order to surface the factors driving health care costs and to identify short-term and long-term solutions that will mitigate growth in health care spending in Massachusetts, it is my intention and the intention of my partners from the Division of Insurance, Department of Public Health, the Office of the Attorney General, to surface different and even conflicting perspectives on what is driving the rapid rise of health care cost in Massachusetts and what can be done about it through public policy and changes in industry practices.

Ultimately this public dialogue

will better situate Massachusetts to contribute its unique experience to the national discussions on access, health care cost containment, quality improvement and offer valuable insight to a final report that the Division will issue to the legislature on strategies for mitigating health care costs and payment reforms.

In terms of format, the hearings today will generally be presented in thematic moderated panels with each witness given the opportunity to make brief openings remarks, answer questions and briefly respond to other comments.

The Division has identified a representative sample of health care providers and payers to serve as witnesses today.

The panelists will be sworn in and will, therefore, provide their testimony under oath.

We, in fact, today will not have anyone submit testimony under oath but we will commence Thursday and Friday.

While the Moderator will ask the majority of questions, the four of us at the head panel will intervene at any point.

In addition, I encourage all of you to engage in the discussion. There are index cards available at the registration table. Please make sure you write any questions you may have for the panelists and give them to members of my team who are here today. Again, index cards are at the front of the registration table when you first come out of the elevator but I strongly encourage you to engage.

At the end of each panel the Moderator will then select some of these questions and ask them of the panelists.

Before we begin, I also want to quickly review the agenda. We will start today with brief comments from several key state officials.

Following their thoughts, we will hear from three of the experts who conducted the research and analysis for the Division's preliminary reports on health care costs released in February -- Cindy Parks Thomas of Brandeis University's Heller School; Dianna Welch of Oliver Wyman Actuarial Consulting and Deborah Chollet of Mathematica Policy Research.

Their presentations will be moderated by Professor Stanley Wallack of Brandeis University's Heller School.

Later when we hear from the Division of Insurance regarding their hearings, an analysis and expert witness economist, Len Nichols, on "What is the Cost of Doing Nothing?"

There will be a short 30-minute break for lunch. The cafeteria is on the first floor. And we will promptly again at 1:15 with the Attorney General, Martha Coakley and she will be followed by two panel presentations with employer and consumer representatives respectively.

Hopefully, if we can stay on schedule, and I do have a gavel, we should conclude today at 5:00.

I am going to now ask the panelists

to join us, if you don't mind, before we go into the formal agenda.

Cindy, and the others, if you don't mind just coming up to the table.

(Panelist seated at the table.)

COMMISSIONER DAVID MORALES: At the time I would like for -- if you don't mind -- we are going to take a couple of minutes break just to make sure that the mikes are functioning with the panelists and we will begin promptly by Governor Deval Patrick followed by Senate President Murray.

Thank you for your patience. We will be two more minutes.

(Short Pause.)

COMMISSIONER DAVID MORALES: Good morning. We are going to continue this morning's program at the hearing.

At this time it is really an honor and pleasure to invite to the podium Senate President Murray.

(Applause from audience.)

SENATE PRESIDENT MURRAY: Thank you, David. Good morning, everyone.

I thank you for inviting me to participate in these very important public hearings.

Two years ago this month Senator Richard Moore and I introduced comprehensive legislation to address the rising cost of health care.

We made the case that controlling costs increases was essential to our long-term economic growth and the sustainability of our health care reform law.

A key piece of that legislation was requirement that the Attorney General and the Division of Health Care Finance and Policy hold annual public hearings to examine health care cost drivers and hold insurers and providers accountable for costs increases.

And today represents the first time those required hearings are being held and I want to thank the Commissioner for scheduling them.

Health care costs are the No. 1 issue facing our economy and the urgency to bring down costs is greater than ever.

We are at a crossroads and we must take the path of action -- failure to act is not acceptable.

Health spending has reached a level where continued annual increases of three to four percentage points higher than the state's economic growth will increasingly inhibit employers' ability to create jobs and our state and local government to maintain other essential services.

In short, health care costs continue to squeeze our state's finances and make it increasingly difficult for young people, families and business, large and small, to make ends meet.

Overall Massachusetts spending on health care is 15 percent higher than the rest of the nation. These hearings will help eliminate why this is the case and what the state and insurers and providers can do to slow cost growth.

And these solutions can't just come from government alone.

These hearings are designed for other voices -- those of consumers, business, business' people, doctors, hospital administrators, insurance company representatives and health policy experts -- all offering information and recommending solutions to the cost problem.

It is time we get a handle on health care cost drivers which have been a problem for too long even before our landmark Health Care Reform Act of 2006.

Health care reform was Step One and as a result more than 97 percent of Massachusetts residents now have coverage.

Step Two is Chapter 305 our Cost Containment Law passed almost two years ago which is essential to making sure that health care in Massachusetts continues to move forward.

The law attacks costs on several fronts and these hearings are a requirement that will help us identify why we continue to see significant rate increases every year.

The Attorney General's preliminary report from January begins to identify some factors associated with premium increases in Massachusetts.

It also sheds some light on market inconsistencies and practices by insurers and providers that will help direct solutions and future legislation.

Together with the information we uncover from these public hearings, we should get a handle on the complexities of cost drivers and get some answers on how to put the brakes on and start putting costs in the other direction.

These hearings are truly unprecedented in both scope and depth and reflect our shared commitment of thoughtfully addressing this complicated issue.

And once these hearings are over, we must act quickly and decisively to make the solutions a reality free from bureaucratic red tape and complete with the knowledge and wisdom of people who work in the health care field every day and those most effected by the hardships in increasing costs.

The testimony and information presented in the next few days must continue to inform our policy agenda for this session and far beyond.

This will be our time to take action and bring relief to families and small businesses while also setting course for long-term payment reform.

Thank you, again, for your time and your commitment to this important issue and we look forward and the rest of the legislation looks forwards to results.

Thank you.

(Applause from the Audience.)

COMMISSIONER DAVID MORALES: Thank you, Senate President Murray.

Now, I would like to call Secretary Judy Ann Bigby, Secretary of Health and

Human Services to the podium.

(Applause from the Audience.)

COMMISSIONER DAVID MORALES: And I would also like to acknowledge Attorney General Martha Coakley who is with us today.

(Applause from the Audience.)

SECRETARY JUDY ANN BIGBY: Thank you, Commissioner Morales and thank you, all, for being here this morning.

I want to acknowledge your colleagues at the podium, Tom O'Brien and Joe Murphy and also, thank you, Senate President for your leadership in making sure that these hearings actually happened today and in the years to come and thank you, Attorney General, Martha Coakley, for your partnership and dedication in making this happen.

I appreciate the opportunity to address you today as we come together to address a critical challenge of the rising health care costs.

As the Senate President said, now is the time to really address this because we have achieved near universal coverage in Massachusetts with 97 percent of the residents with insurance.

While this is an amazing accomplishment, we must move forward to improve both the quality and affordability of health care so we can maintain and improve access to care.

So this is not just about containing costs. It is about making sure that we maintain access and that we are providing the highest quality of care that we can provide to residents of Massachusetts.

Simply put, we must restructure the system of delivery to a high value health care system that is less costly, more efficient, more equitable and produces better health outcomes.

During these hearings we are likely to hear many perspectives about the problems that create high health care costs and how to address them.

I suspect that much of what we hear

we have heard before but this is the first time that we will all be presented in a comprehensive manner.

We all will understand why we have soaring health care costs and how they are barriers for individuals and businesses.

And this is the time that we need to address this problem as we are attempting to rebuild the economy in Massachusetts.

Recently the Governor made recommendations about ways to address the costs, the rising costs for small businesses, but we know that these are not long-term solutions and that we must move on to help bring insurance costs under control for businesses, but also make health care more affordable for individuals and for government.

As the Governor noted in his testimony last week to the Joint Committee on Health Care Financing and Community Development and Small Businesses, these steps are simply a jumping off point for reforms that will bring long-term solutions.

As such these hearings represent a critical juncture for cost containment conversations in the Commonwealth.

One of the features of our health care system that is a barrier towards making a more efficient system of delivery is the way we pay for health care and I hope that the dialogue that takes place over the next few days will address this critical and complex issue and explore the ways that we can move from a fee-for-service payment system in which doctors and other providers are paid for each service they provide and is increasingly seen as a barrier to effective, coordinated and efficient care.

Fee-for-service rewards, the misuse, overuse and duplication of services and favor costly specialized treatment over preventative and primary care.

Primary care physicians, psychiatrists and others who I call who deliver bread and butter medicine have gotten the message.

Their services are not as valued as

of those of specialists and it is reflected in the stories we hear about barriers to access to care.

Changing the way we pay for health care by moving away from a primarily fee-for-service system is the only way we can achieve transportation to a better system of care and one that ideally lowers the rate of growth and health care costs. Incentive should support full vertical and horizontal integration of providers and services with patients having access at multiple connected points.

Care is more coordinated for patients who seek it for more organized delivery models such as an integrated delivery systems and physician practices that are based in the primary care centered -- a patient-centered primary care medical home.

Delivery of care within among provider organizations and insuring care coordination across the sites of care especially from when transitioning from the hospital to other centers should also be a key objective of system redesign.

I urge you to consider effective payment reforms that will push the system away from disorganized poorly coordinated and inefficient care away from care that may not take into consideration patient preferences resulting in unnecessary and unwanted procedures and innovations, away from policies that result in an undersupply of primary care providers and an oversupply of other specialists and away from care that is delivered without attention to clinical science.

Failure to take immediate and lasting action will result in continually rising health care costs which will continue to burden not only our state's individuals and businesses but also state government.

Thank you very much for your attention to this and I look forward to seeing the outcomes from this several day process.

(Applause from the Audience.)

COMMISSIONER DAVID MORALES: Now it is my honor to invite to the podium, His Excellency, Governor Deval Patrick.

(Applause from the Audience.)

GOVERNOR DEVAL PATRICK: Thank you very much.

Thank you, Commissioner Morales and Commissioner Auerbach, I think is coming soon, Commissioner Murphy, General O'Brien, General Coakley, Secretary, thank you all, thank you members of the panel, Ladies and Gentlemen. I am going to be very brief and to the point.

Since the implementation of health care reform in Massachusetts, you all know we have made incredible strides in ensuring access to health care.

Today over 97 percent of our residents have health insurance today. Not another state can touch us.

By any measure, it has been a remarkable achievement but like every other state and locality, health care costs continue to rise and to rise sharply.

It effects our economic growth, the stability of local communities and our ability to continue to lead the nation in health care.

Soaring health care costs rising far in excess of medical inflation are especially hard on small businesses, preventing growth at the moment we need it most.

Companies with fewer than 50 employees make up 85 percent of businesses in our Commonwealth. They are the undisputed engines of new job creation and economic development but small business owners are paying 74 percent more in monthly premium costs than they were just a decade ago.

Since 2001 the median cost of health care for an individual employee has increased by 76 percent.

Year after year small businesses and their employees have been disproportionately hit with double digit health insurance premium increases. The payers and providers in the health care industry are as smart and as creative as they come. They have participated constructively in developing long-term responses to these issues but without a short-term solution our economic recovery is in jeopardy and on that score, the response of the industry has frankly been lacking. The situation is stark.

If health care costs for small employers are not contained, they cannot create jobs. If they don't create jobs, we will have no economic recovery.

Our opportunity, indeed our responsibility, right now is to work together towards a simple goal -- lower health care costs for small businesses and working families in Massachusetts.

If we fail to act, the job growth we need right now will slowly suffocate.

Last week I testified in front of the Joint Committees on Health Care Financing and Community Development and Small Businesses. The Senator is here and I thank you, again, for that hearing.

We testified about our regulatory and legislative proposals to provide immediate health care cost relief to small businesses throughout the Commonwealth.

Proposals including all oversight of health insurer and provider rates to protecting small businesses from rate shop will help bring health insurance costs under control. These measures are intended to be temporary in nature to help us through the current emergency but, as I noted then, we need you to address the fundamental reasons health care costs keep going up.

To that end, the Payment Reform Commission has made serious recommendations about changing the way we pay for health care.

Today's model based on fee for service as the Secretary was describing a moment ago too frequently leads to higher spending and inefficiencies as we reward in effect for the amount of care delivered.

If we want to tackle the problem at

the core as the Commission proposed, we need to consider a system that rewards the right care in the right place at the right time.

Inputs and cooperation from leaders across the industry and in government and in business have produced these important recommendations and I commend them to you for your consideration.

I want to the respectfully caution you against being defeated by the complexity of this issue. It is indeed complex. There is no doubt about it. But after years of circular conversation with industry leaders, the cost burden on small business and working families has just gotten worse. We need payment reform implemented carefully and methodically to get us a long-term fix. We also need interim cost containment measures such as we have proposed as a bridge from here to there.

I urge you to support both. Thank you very much for having me.

(Applause from the Audience.)

COMMISSIONER DAVID MORALES:

Thank you, Governor.

At this time I would like to invite Chairman of the Health Care Finance Committee in the Senate, Chairman Moore.

(Applause from the Audience.)

SENATE CHAIRMAN MOORE: Thank you very much, Commissioner. And I, like the President, I am also pleased to have been invited to provide some remarks this morning as we begin these really historic hearings.

Massachusetts, based on our landmark health care reform efforts is the highest rate of residents for health insurance in the country. However, it would be premature for any of us to raise the mission accomplished manner over the golden dome.

Our mission will not be accomplished until we can proclaim that the health care that is delivered -- that this insurance lives us up to our region's representation for the highest quality health care while ending our reputation for the highest cost of health insurance.

Frankly, small businesses, which are the economic engine of America and Massachusetts, are not especially impressed by the 97.3 percent of Massachusetts residents with health insurance.

The percentage figure that increasingly grabs their attention is the doubts digit increase year after year in their insurance cost. They won't be cheering for the raising of any mission accomplished unless the sign on their own business is flipped to open and their bottom line is in the black.

However the rapidly increasing cost of health care in this state makes the goal of small businesses to stay open and our goal of successful health insurance reform increasingly elusive.

They are seeing rate increases of 25 percent, 40 percent of more and too often those additional costs come right out of their own wallet.

Combined with the financing of a child's education, meeting a looming mortgage payment, increasing food and utilities costs, health care costs for the employer and his or her employees make the cost of doing business in retaining workers or hiring new employees extremely daunting.

According to a recent report by the Commonwealth Fund, a nonprofit health care foundation, the cost is severe. In 2008 the average premium for plans offered by employers in Massachusetts was $13,788.00 which was 40 percent higher than in 2003.

Comparatively, the nationwide premium increase was 33 percent. As policy makers, we need to be concerned about keeping the costs of health insurance closer to the national average if we are to remain competitive with other states for jobs and economic growth.

If we continue to overlook the small business owners and those individuals teetering between employer-sponsored insurance and state-offered plans, our small businesses will continue to feel the pressure and burden of sharply rising costs and our economic recovery as the Governor suggested, would be far more difficult to achieve.

The Division of Health Care Finance and Policy has confirmed the Commonwealth Fund's findings: Premiums for employers with 50 or fewer insured workers grew faster than premiums for mid-size or large employers with 500 or more covered employees. This means that without significant cost reforms an annual family premium in Massachusetts will soar to an unfathomable $26,730.00 by 2020.

Business owners are not unlike their employees. They struggle and they take home less and make sacrifices necessary to stay afloat but for those of businesses that have been fortunate to remain afloat, rising premiums may well be their perfect storm. By being partners in care, partners for success and partners against failure and partners in recovery, we may be able to provide the lifeline that is necessary for these small businesses.

Consequently, the first goal of these hearings must be to aggressively and immediately address the rise in small business health insurance costs.

The Division of Health Care Finance and Policy reports demonstrate that the engines of our local economies are bearing a disproportionate share of health care costs and increases.

I have struggled to understand this alarming trend especially considering that the Commonwealth stands nothing to gain from permitting innovation or new employment to be stifled, particularly in such a crucial sector of our economy.

It is, therefore, my hope that these important hearings produce recommendations for the immediate relief and stabilization of premium increases so we may set the foundation for sound economic recovery -- a recovery that no doubt will largely be driven by our small businesses.

While central concern for the hearings that begin today may be the immediate relief for the small group market, we must also begin to focus our attention and action on long-term systemic change of our health care system, and the resources that we devote to it.

The effort which we have labeled "payment reform" has the potential to transform our dysfunctional delivery and payment system from that which rewards volume and complexity, into one that rewards quality and value.

In doing so, we will be able to control the growth of health care costs, not only for small businesses, but for all businesses, individuals and even government.

In the process, we will also be able to create a more coordinated, patient-centered system for the consumer such as the Secretary described.

Economists tell us that Massachusetts is a high cost of living state, but that should not be a reason for us to accept higher medical costs that are not explained by high quality care. My colleagues in the legislature and I cannot tell our constituents, many of whom are middle class families, that just because they live in Massachusetts, they have to pay more for their health care.

It is even more difficult to confront that reality when those same people are struggling to make ends meet in this brutal economic climate.

Frankly, the current system fails those individuals or families who aren't eligible for premium assistance or Medicaid we must pledge today to do better for them.

Some misinformed pundits claim that the Massachusetts Health Reform postponed the need to improve quality and contain costs for the sake of addressing access. Considering that I helped to craft Chapter 58 the Acts of 2006 and its companion legislation, Chapter 305 of the Acts of 2008, I can attest that cost and quality have always been part of our reform efforts.

However, expanding access to care can be achieved much more rapidly and produce tangible results more quickly compared to the more difficult time consuming and complex tasks of improving the quality care of care and reducing costs.

From Day One, with the historic passage of Chapter 58 in 2006, we set a clear message that no reform would be complete or successful without striking a balance between access, quality and cost.

Some of the efforts obtained within Chapter 58 to address quality and cost include -- establishing the Commonwealth Connector Authority with the authority to establish rules for meaningful health insurance coverage and contain costs; establishing the Massachusetts Quality and Cost Council to measure and compare provider costs and lead quality improvement and cost containment efforts, linking hospital rate increases to adherence to national quality standards, initiating a computerized physician order entry program to advance health information technology adoption to better coordinate care and reduce errors.

And the list goes on, ranging from promoting wellness and prevention to encouraging the use of primary care physicians as opposed to the more costly Emergency Department use.

The passage of Chapter 58 was never intended to be a silver bullet that cured or ailing health care system. It was always our intention to set the stage for more targeted reform efforts, which includes specific cost and quality measures, and eventually a complete overhaul of our payment system.

With the passage of Chapter 305 in 2008, we provided additional and enhanced policies to further, and more explicitly address the cost and quality components of health care reform which include, establishing the Massachusetts eHealth Institute and providing significant state support for meaningful use of health information technology, which includes establishing goals and timetables for physician competency in that use, initiate reforms to standardize bill coding to reduce administrative expenses; establishing programs to expand the number of primary care providers that sits through a larger class at the state medical school, financial aid for primary care providers, expanded use of nurse practitioners and physician assistants.

Establishing strength and guidelines for the determination and need for expansion of health care facilities and that list goes on as well ranging from the establishment of the recently completed commission on payment reform to mandating this very hearing that I have the privilege to address today.

Of course, not all of these accomplishments have been fully implemented either because they take time to establish effectively and correctly or they cost money which we all know is a little scarce these days.

However, the legislature sent a clear message regarding its priorities and what it believes are the necessary ingredients in any successful and sustainable health reform effort.

As I said at the outset of these remarks, our work is not complete. Our mission is yet to be accomplished. Many areas of our health care system are in dire need of reform and any attempt to do so will not be without controversy.

In fact, the idea of moving to a global payment system is so controversial and so time consuming that the Special Commission on Payment Reform recommended phasing it in over five years.

Equally as controversial is the notion of medical malpractice reform, which drives the costs of wasteful, defensive medicine and far too often produces little or no justice for victims.

There are several other areas where, if addressed, we may realize significant savings and produce additional transparency throughout our system.

Research into provider-payer contracts has revealed and through the good work of the Attorney General, that regardless of quality, the market share alone can drive skyrocketing costs. Other reports have shown that limits on insurance companies' administrative costs and profits, or changes in the way doctors and hospitals are compensated can produce better quality care outcomes at significantly less cost.

According to the Commonwealth Fund's report, doing so may produce a savings of two to three trillion dollars nationally suggesting a potential savings for Massachusetts in the hundreds of millions of dollars.

These issues must be considered and we must engage in a debate to find the best outcomes.

Neither Chapter 58 nor Chapter 305 were drafted or passed by the legislature over night. They underwent careful review and were the product of selfless compromise and negotiation from all of the players in the health care field.

However, the small businesses and

individuals facing double digit premium increases across our state cannot wait until the next month, never mind until the next legislative session.

The Governor and the Senate have both proposed interim measures that would cap growth in provider costs and premium increases. Nobody has claimed that these are the best solutions or that they are even sustainable as long-term solutions.

In fact, such caps over time shift cost to other parts of our economy and reduce choice sometimes compromising quality in the delivery of care. However, if we continue to force businesses to choose between paying for health care for their employees and keeping their doors open, Massachusetts will never see true economic recovery and job growth.

Of course, small businesses are not the only sector suffering from overwhelming premium increases. I constantly talk to constituents whether elderly, unemployed, college graduates just entering the employment market or hopeful retirees desperately seeking a way out. Recently senior citizens have expressed genuine anxiety over increases in their Medicare supplemental insurance.

Individuals, businesses of all sizes and even government at local, state and national levels have expressed growing alarm at rising health care costs.

Each and every story adds proof to the maxim that nobody is immune to harm from a faulty system and something must be done. As such, the legislature's urgent hope for these hearings is two-fold.

First we hope to gain a better more comprehensive understanding of the pressures driving the cost of delivering care and the rising price of the insurance to pay for it. Secondly, we hope that all providers which include acute care hospital, physicians, skilled nursing facilities, pharmacies, allied health fields and all payers, including insurance companies, health plans, government agencies, self-insured companies, and individual citizens, will tell us what they are doing and will do to reduce the costs of care without sacrificing universal access or without sacrificing improvements in quality of care.

As I mentioned earlier, we are all partners, whether it be in success or failure. Hopefully, we can be partners in achieving high quality health care at an affordable level for everyone in the Commonwealth.

Some may argue that the task is too daunting, but I look forward to joining with everyone here today and in the hearings over the next several days rolling up our sleeves and getting to work.

Senate President Murray and I look forward to the findings and recommendations of these transparency hearings this year and the annual hearing that will follow in the years to come as we continue to steer the ship in the right direction towards better quality and costs as well as access to everyone.

Thank you.

(Applause from the Audience.)

COMMISSIONER DAVID MORALES: Thank you.

At this time I would like to invite the Chairwoman from the House of Representatives of the Health Care Finance Committee, Harriett Stanley.

(Applause from the Audience.)

REPRESENTATIVE HARRIETT STANLEY: These remarks are so typical and I am going to borrow, quote, the Governor's opening words from his testimony before the Health Care Financing Committee last week, the Governor's words were "enough is enough" and my paraphrase is simply enough.

We finally have enough data and I have been thinking this morning I have been associated in some way with eight different administrations in the Commonwealth and the work done by the AG's office is probably the best I have ever seen in eight administrations.

We finally have enough studies.

They stand about that high on a table in my office and we are beginning to have enough analysis -- so again, enough, we need to get going and this morning is a good time to start.

Thank you.

(Applause from the Audience.)

COMMISSIONER DAVID MORALES:
Thank you.

I would like to now invite -- I am honored to invite actually, the Vice Chairwoman of the Health Care Finance Committee, Mary Grant.

(Applause from the Audience.)

VICE CHAIRWOMAN MARY GRANT:
Thank you, Commissioner and to all of you who serve on this panel and address this weighty issue.

I particularly wanted to come here today because I had a message that I felt I needed to deliver. So I will put it in context.

I am the Vice Chair of the Health

Care Financing Committee. I am also a Registered Nurse. I have a Master's Degree in Community Health Nursing. I have served 30 years in the clinical field working for the Department of Mental Health, seven years, that was here in Boston in the mental health center writing children's service programs, seven years in Cape Ann running a sexual abuse treatment service out of a criminal justice grant. All of my clinical experience has been in the community setting.

I also have had my own practice for 14 years and of those 14 years I spent five years doing my own billing so I have the experience of not only the details of billing but also the issue of arguing for payment and rejections and whole the system that goes on. I am in the area of mental health which is a little different.

You sometimes have to do a little more arguing for what you want to do because things aren't classic often or they are not often run in the main stream of the health care system.

So I have three comments that I wanted to make today as you deliberate the testimony that is coming up over the next three days -- impressive panels, very thorough, but let me start by staying I know these hearings are prescribed legislatively that they have to have annually.

I happen to think that this year we are in the position where there is the issue of the day nationally and what happens and what we do with the rich information that we can get in the next three days of testimony and what we do with it will impact I believe not only the citizens of Massachusetts but also what happens nationally if we do it right.

Secondly, we have come as several people have mentioned to the limit of our ability to pay as we are now being charged. We can't do it. People can't do it. Businesses can't do it. Institutions are struggling -- every single part of the system is. We have known it for a long time. This isn't new. It has clearly come to a head.

The big black hole of where all of these extra charges are going has to be defined and explained in context with transparity, transparency and clarity if we are to move forward on the issue. If we can't do that, we can't move forward.

We have taken care of all of the edges of this elephant and we have not gone at the belly of the beast and that is my third message.

Payment reform commission made a proposal to start this. My greatest concern in any large effort like this is that clinical practitioners have an equal part at the table in deciding how this money should be spent.

We continue to weigh councils, commissions -- whatever -- I have to now read because I can't see any longer, with insurance representatives and institutional administrators, agency representatives all with wonderful perspectives but when the doors close, there is also no pure clinical voices -- a voice that actually knows what the impact will be on the physical health of our general public to move billions of dollars from one part of a payment system to another.

We have made this mistake several times over the past 25 years and so changes that we have attempted to make have not held because they aren't clinically sound. They don't work in the office. They don't work for patients and they don't work for people like myself who are delivering the service because they would not be what you would decide to do clinically.

So people work very hard in the clinical system to adjust the service that they are delivering to try and help a patient use their insurance benefits. This is a very backward way of working and it is absolutely not the most effective way to use our money.

Often times if a person who runs an institution has a clinical degree and serves on those panels, that is a big help.

We happen to have a Secretary of Health and Human Services who has been a practicing physician -- that is a very helpful thing and a very helpful perspective but, unfortunately, sometimes when one is in charge of an institution and holds that clinical degree, they have a double loyalty here. One is to protect the institution -- it isn't always to make sure that the care that goes to the patient is the most effective or efficient so we have to keep in mind that the active practitioners are who needs to be part of this conversation. People who see patients coming in the room.

And it took me, for instance, several years to get Chapter 58 to reflect that there must be in the legislation that there must be at least one practicing clinician on the Quality and Cost Containment Council.

When we passed Chapter 58, that is what I thought was one of the most important parts of the bill because I knew access and affordability was important because everybody had to be in the pool or nobody was going to discuss money.

Now that everybody is in the pool, we are all talking about money as we should be.

One out of those 16 people are required to by law to be a practicing clinician. We happened to have lucked out because by the nature of the position they hold we have had some other clinical input in those discussions but we haven't protected that.

When we did the Payment Reform Commission, there was one clinician out of 12 sitting on there.

I just say this because we would not have institutions delivering health care nor would we have any products for insurance companies if we didn't have the clinicians because there wouldn't be anything to sell insurance for and there would be nothing happening inside of the buildings.

They are the ones that have

educated themselves for many years in determining what actually works for us.

I want to, as I close here, I want to give two concrete examples of how this happens and then just pull it together.

We talk about case management as we look forward. We talk about medical home to coordinate care. Everyone talks about this including insurance companies -- that is the most effective way to do it but, for instance, and this is a little "for instance" but it is part of the issue. There is refusal to pay for collateral contacts.

Now Medicaid did this as well in the mid '90s. They stopped after two or three years because collateral contacts is how you manage cases and if you can't do that, then you can't manage.

Secondly, it is other issues of things we cut out. For instance, an ongoing issue that has gone on for as long as I have been practicing, is and I got a repeat call about an ongoing issue of a school-aged child who has exhibited several neurological symptoms which clearly will impede their ability to learn as they go along through school. But they don't have to, okay, if paid attention to but they would without understanding them.

A pediatrician refers the child for a neuropsychological evaluation as the child begins school. The insurance company refuses to pay.

These are not little insurance companies. These decisions come from our big insurance companies.

Refused to pay -- we don't cover that -- how does that get decided? Does it get decided by cost alone? Does anyone making that decision know the impact?

A neuropsychological evaluation for a kid in that instance has often been the blueprint for that child's success for his entire 12 years in school.

And if that blueprint is wrong at the beginning, they can go through four or five or six years in elementary school and not understand why they are not learning.

So these kinds of things are the blueprint.

I have argued many times over the years for why that has to happen and clinically why that has to happen and still I am in this is position still getting calls about the refusals happening.

It is put off and put off and then the answer this week I got was I understand the school system is going to do an evaluation -- okay, here is an issue of money -- let's track the money, school systems to do evaluations -- some very well, the evaluations are geared towards learning only.

When a pediatrician refers for a neuro psych evaluation for school age, this isn't just about learning. It is about life functioning as well as learning and the two are not the same.

So after a year of fighting, first of all, one is more -- I told you that one is more heavily learning oriented, secondly the situation clearly to me on some level looks like the cost avoidance for an insurance company moved over to a public school but the saddest part of all is this child and this happens all of the time has lost a year of intervention at a critical point in their life.

So as I, in summary, I guess my messages are please actively listen to all of this. We can't have a big impact if we get it right.

Secondly, we have to remove the veils within the system that clouds our vision and prevents us from getting it right for the general public and patients.

Thirdly, ensure a strong clinical voice at a decision table to ensure that billions of dollars are clinically effective.

Without this, it does not matter what the balance sheet looks like as we will be leaving a less functional citizenry.

Thank you very much.

(Applause from the Audience.)

COMMISSIONER DAVID MORALES:
Thank you.

Are there any other elected officials that I may have missed in attendance?

(No Response.)

COMMISSIONER DAVID MORALES: All right, what I would like to do very briefly is 1, go over today's agenda again and talk a little bit about process and, again, to update everybody from this morning's introduction, we are going to move onto health care finance and policies and research experts to have them briefly walk through their findings, after that at 11:15 we will have Commissioner Murphy speak to his findings and some of the research that he has done through his hearings and then we will go on at 12:00 to hear from Len Nichols, a nationally respected health care economist and then we will have a half hour break or so for lunch at 12:45.

Around 1:15 we will have Attorney General Martha Coakley and have her review her presentations and her finding with her team so her team will do an employer panel and then around 3:30 a consumer panel and lastly the last point I want to make to make is just to make sure that everyone if interested engage today.

So you will see some members of my team going around that will have index cards that you can write your questions on.

As you listen to the testimony, to the presentations -- if you feel the need or the interest and I encourage you to raise your hand and we will distribute some index cards for you to write your questions and the Moderator in this instance, Stan Wallack, will handle and select which questions to ask.

So, Professor, if you will, please, Stan Wallack.

(Applause from the Audience.)

PROFESSOR STANLEY WALLACK: Thank you, Commissioner, and good morning.

I have met some of you over the 30 years I have been at Brandeis.

But most of these social and health policy gatherings -- 30 years ago Brandeis became the first outside cooperative research department for Medicare. As a result, I have conducted numerous studies, developed demonstration for Medicare, designed payment systems for the medical government and while small actions, the Federal government can make huge impact or chaos, I have come to become more attuned with Judge Louie Brandeis' belief that states are the laboratory for real change in this country and early in my career also as a Federal Government official, I often made policy based on some observations, personal observations about what works.

Some of you, particularly my wife, Anya Rader Wallack, who some of you know, may say that the reason I became so interested in state health policy is because of her passion. I can't argue completely with that but the reason I have become interested is because I believe we can make a difference starting in one place.

An example of that is one of the Brandeis demonstrations through Medicare was the physician group practice demonstration which has now become morphed or changed into the model for the accountable care organizations.

We put the backbone together for doing that model, the share savings model, setting up quality standards, etc., and that has become so successful in its own small limited way that now people are looking at the accountable care organization as a viable alternative to bring about for the whole country.

(Discussion off the record.)

PROFESSOR STANLEY WALLACK: The reason why Brandeis decided to be a strategic partner for the Commonwealth, understanding the determinants of health care cost and cost drivers and assist them for developing policy solutions is really because of the importance of the issue.

This is actually the first state project in my whole time as a health policy expert and analyst that I have ever done a state project and I know that addressing the cost growth cannot be done in a piecemeal fashion by some part of the health system.

We all talk about this balloon you press it in on one side and it comes out the other side.

States I think do hold the promise for being the right level for being the coordinator of cost containment and just as Massachusetts has led the country on universal coverage, this is the state that can lead the way for the country to cost containment.

Health care cost growth is a challenge for the whole country. You have heard that from our speakers today, the officials.

Moreover, the states hold, I think, economists as being, you know, as I said before, the right level for moving forward.

As you will see today, our cost growth and the urgency for Massachusetts is even greater.

We have higher costs and we have higher cost growth.

When the Massachusetts Universal health care plan was passed, it was the general expectation that cost containment would follow as the next step for the very simple reason we heard today.

That if costs growth continues to exceed the growth in the economy that the state could not be reformed and it could not be sustainable for the Commonwealth, for employers or for individuals.

Now we are fortunate that we have established a strong working relationship between the private and public sectors in Massachusetts.

This is important because lowering the cost trend will require a community wide effort for providers, for policy makers, academics on both what I call as an economist the demand side of the health equation as well as the supplier side if we are going to improve the long run efficiency of the Commonwealth's health care system.

Now Chapter 305 created the urgency of cost control -- about cost control and it is even more urgent now with the downturn in the economy as we heard and we can't wait.

The legislation required the Division of Health Care Financing to do the same report on spending trends and underlying factors and recommendations and steps toward the end report have been taken already. We have done some of the strategic reports we are going to be talking about firstly this morning.

These public hearings are to present the findings that allow the interest of all of the affected stockholders to be expressed.

The recommendations are going to follow these hearings and so, really, I support the Commissioner in saying we really want to hear from you.

Now there are limitations to the first year's report. First, they only covered the years 2006 to 2008. Secondly, we are able to report what the major cost drivers are but we have not yet had time to analysis some very important questions about why.

Over the next two days or three days of hearings we hope to learn a lot from the insight of providers and health plans and individuals about why.

And, third, the first year's analysis has been done only with the claims experience of private payers and subsequent studies will add the 2 million individuals that are covered by Medicare and Medicaid.

Now the legislature, I think, recognized in saying we should first look at the private sector because that is the big hole as we look at health care costs and that is the one that we had to address. About 60 percent of Massachusetts residents are covered by private insurance. We know little about what is happening in terms of the costs, in terms of the trends.

So our first year reports are really based on what is going on in the private sector. And, as I said, in the next couple of years, we will add Medicare and Medicaid, so we will accomplish a complete picture in what is going on in the economy with regards to costs.

This study as David Morales has said is done by a team -- a team from Brandeis, Mathematica, Oliver Wyman as well, I should say, we have worked very closely with division staff. They were instrumental in getting these reports done.

So what I am going to do in my role as Moderator now is to allow each speaker to present for about 10 minutes and highlight their findings. As you all know on the web there is some long reports there.

They are going to try to give you the highlights and the major points that they want to bring home to you.

I will introduce them all now and there are short bios provided to you in the folders. You should all look at those. It is a very impressive group today and for the next couple of days.

So Cindy Thomas, an Associate

Professor at Brandeis will lead off.

Cindy was the Project Manager in our role as the strategic leader and as manager of these studies and she is going to do the first presentation looking at the first report which is the context. Let's look at Massachusetts in the context of the whole county.

We need to put ourselves -- we need to understand that we are different but not that different but what moves costs generally is what moves costs here.

Cindy is going to be followed by Dianna Welch. Dianna is at Oliver Wyman and Dianna is the lead actuary on this spread analysis. Dianna is well known to some of you because since she spent four years at Blue Cross prior to going to Oliver Wyman.

The last presenter on the panel is Deborah Chollet. Deborah is a senior fellow at Mathematica and Deborah has led the Mathematica analytical team and has done prior work for the state including being a consultant to the Payment Reform Commission.

So Deborah will be the last presenter.

We will have the three presentations and then I will begin with follow-up questions, but, again, for the various members here at the head table as well as for the audience, I will be glad for you in the audience to forward your questions on.

MS. CINDY PARKS THOMAS: Thank you, Stan.

For the better part of this year I have been assisting the Division in preparing health care costs trend reports and I want to thank Commissioner Morales for providing us the opportunity to contribute to this very important effort.

I just want to start by acknowledging that any interpretation of data, consideration of recommendations or moving forward towards solutions rests on having a thorough understanding of the strong Massachusetts health care system, its features related to health care costs and cost drivers and a little bit of history and knowing where Massachusetts sits in comparison to the rest of the nation.

With that I will briefly review the findings of Part One of the health care costs trends drivers, Massachusetts -- I will make four points today.

Massachusetts health spending is higher than the nation.

Second, the structure of the Massachusetts health care system is charged by specialization, academic medical centers and open health care networks.

Third, methods used by health insurers to pay providers are really mostly all fee-for-service even within managed care organizations.

And I will conclude with some places where there are opportunities to provide increased efficiency in the health care system.

I would like to just begin by saying Massachusetts health care system is a critical component of the state's economy. It is the largest employer of Massachusetts residents and accounts for over 13 percent of the gross state product.

We rank first among states in access of care according to the Commonwealth Fund and seventh among states on overall health system performance.

Massachusetts hospitals are often cited as among the best in the nation in terms of quality of care delivered and Massachusetts health plans as we know are consistently rated among the top ten plans nationwide.

At the same time we as the rest of the nation are grappling with escalating health care costs consuming a greater portion of the economy and lowering real wage growth as you have already heard this morning.

Some of this cost growth is driven by system-wide challenges such as an aging population and greater use of high technology services. Some challenges such as those that stem from the structure of the system and the marketplace are unique to

Massachusetts and must be considered as we identify strategies and that is what I am going to talk about.

First of all, Massachusetts spending compared to the rest of the nation -- as you can see, the bottom line represents the United States. These are data provided by the National Health Accounts. The state data is only available from 2004 which created a greater challenge for us to understand where Massachusetts lies compared to the rest of the nation as well as really confirms the importance of the findings -- of our research now in identifying health care trends over the past several years.

U.S. per capita spending more than doubled since 1992 growing 5.5 percent per year. Massachusetts at the same time went from 22 percent higher health care costs than the nation to about 27 percent.

If Massachusetts stays its 27 percent in 2008, that means that we would have an average unadjusted per capita spending of $8,100.00 per individual per year.

Some of you have seen more recent health growth trend reports on the national level. This is the first year -- the lowest in many, many years -- the health care cost trends have decreased.

One of the estimates is for personal health care it has gone down to 4.4 with a cap of 3.7 percent. So we will be curious to see what happens when National Health Accounts updates the state level trends to see where we sit.

Well, we are a different system and when you adjust, we take our state spending but when you adjust for the amount of revenue hospitals get that is non-patient revenue that is contributed in terms of research and investment income, we are a little bit less out of scale and then when you further adjust by wage index, we are a relatively high wage state -- the difference decreases to 15 percent higher than our national spending.

What is interesting is that hospitals rank 18 percent higher than national but we are really most out of scale with the rest of the nation on home health and long-term care and some of this is because we have expanded community services which is -- which is a good thing, however we still -- it results in our having 25 percent higher nursing home utilization and 50 percent higher home health utilization.

Our higher spendings are not only due to utilization but to prices. Utilization from Massachusetts -- we are a little bit higher in hospital care but where we really standard out is the outpatient services.

Now remember this is just hospital-based outpatient services.

We do not have a handle yet on non-hospital use but we are 58 percent higher than the nation in outpatient care.

I want to underscore the fact that prices are also important. As Medicare and Medicaid have decreased their growth in prices, private payers are paying an ever-increasing portion of hospital costs, and we will see a little bit more of that as we go on.

We also as Senator Moore noted, we have higher health premiums -- especially since 2003. We are ten percent higher than the nation -- why is that? One of the reasons is that we have a very generous health care insurance system.

At present according to national data we have 38 percent lower deductibles on average than the rest of the nation.

Let me talk for a moment something we all know -- the structure of the system. We have 80 percent more specialists and 40 percent more general practitioners, more physicians, many more behavioral health specialists also.

A moment on academic health centers -- this is a striking statistic we found. We all know that we are heavily dominated -- have a heavy presence of academic medical centers. Academic medical centers, however, account for 45 percent of hospital admissions compared to 19 percent in the nation.

There is a huge growth in 1993 to 1999 and 2000 when several non-academic centers closed and admissions were moving to the academic centers.

However, they make a huge contribution at the same time. I don't want to diminish that. In 2007 the economic contribution of academic centers was over $4,500.00 per capita.

We are -- of the five United States hospitals that receive the most NIH funding in 2005 -- five of the hospitals that received the most funding were in Boston.

However, prices at medical centers that are academic centers are higher than non-academics centers which you will see in our trends report.

Our insurance system is heavily dominated by PPOs as in the rest of the nation. However, in Massachusetts to be an HMO, you do not have to -- we have more

HMOs, but you do not have to pay providers in any certain way, you have can still pay fee for service which as we have heard several times today does not encourage cost containment and I am going to talk for a moment about those methods used by health insurers to pay providers with.

In 2009 with support from Mathematica, the Division conducted a survey asking carriers how they pay providers.

In general, there is very little capitation. We found four of those no PPOs reported paying capitation. For the HMOs that pay capitation, 16 percent of providers primary care physicians prefer paid capitation and only 5 percent of specialists.

Similar statistics exist on the outpatient side. There is very little risk shared by hospitals in outpatient services. It is usually discounted charges or per visit payments.

So what to we conclude from this. There is a dominance of a fee-for-service system. We have open networks with limited pressure to decrease prices. General insurance coverage which is great and low cost sharing, however, it doesn't increase utilization services.

Greater use of outpatient hospital care in comparison to the rest of the nation. We don't know non-hospital outpatient care yet. It is an important thing to understand where that care -- how much of that care is being provided and where. It is not necessarily being used as a substitute for inpatient care because the inpatient care has not gone down that much commensurate.

And we have high ease of academic centers which have higher prices which provides us finally opportunities that we see in comparing Massachusetts to the rest of the nation for creating -- for obtaining greater efficiency while maintaining our high quality system.

Well, fee-for-service dominance suggests that payment reform is necessary.

Use of more limited networks really warrants consideration. Massachusetts generally low cost share provides a good opportunity to redesign benefits but only in the event that consumers can be educated on using low cost, high quality providers and finally we believe that outpatient hospital care and other services can be moved to less costly setting.

And with that, I will turn to Dianna next. And I think we will take questions at the end.

PROFESSOR STANLEY WALLACK: We will taken questions at the end.

MS. DIANNA WELCH: Thank you.

I would like to briefly discuss now the findings from the premium trends section of the analysis that we performed for the Division.

What we have found was premium trends of about 7 percent in 2007 and 5 percent in 2008.

Now it is important to point out that these are the actual premiums paid by individuals and employers without any kind of adjustments down on our part and because of that that means that any shifts in the population over this time period or more importantly shifts in benefits due to these premiums trends, so, for example, if individuals and employers hadn't reduced their benefits over the time period, these premiums trends would have been higher than what we are reporting here.

In terms of the components of the premium growth that we showed on the last slide, about 94 to 97 percent of the premium growth over this time period was driven by increases in claims cost. There is a couple of reasons for that.

First, claims costs represented approximately 88 percent of the premium during this time period and the claim costs were also growing at a faster rate than the non-medical plan cost -- those being administrative expenses and profit.

So the majority of the increase in the premium was driven by the overall cost of medical care.

When we look at the average premiums by market segment those being small groups, mid-sized groups and large groups we saw consistently across these three years that large groups were paying the highest premiums amounts and they also had the highest trends over this time period.

Now these, again, similar to the previous slides are unadjusted premium amounts and the large reason for the large employers paying higher premiums is that they purchase richer benefits during this time period. They also have totally different characteristics, for example, being more likely to be located in Boston.

So in this slide what we have shown is the results of our adjusted premium analysis. So in order to try to account for those differences in both demographics and in benefits, we took the premium data and adjusted it so that small, mid and large sized groups would all be on a consistent and demographic benefit basis.

The picture changes a little bit when we do that.

Now we see over this time period that small employers had the highest premium trends during this time.

Also not shown on this slide -- small employers were paying a higher premium amount when we made those adjustments.

For example, in 2008 small employers were paying about 5 percent more than mid-sized groups and about 6 percent more than large groups when adjusted to consistent benefits and demographics.

I would also note the higher premium trends for small groups during this time period were driven by higher claim costs.

What we will see a little bit later is the difference in administrative expenses and profit between small and large groups actually narrowed during this time period. So the larger trend really is being driven by higher increases in medical claims costs.

So now we have been eluding to the

benefits a little bit already.

We will look at the benefits over the study period. This chart is showing the median actuarial value by market segment where actuarial value is a measure of the richness of the benefit plan and here we are showing just the most popular products.

So for the most popular product we can see that all group sizes reduced their benefits during the study period. We can also see that small groups had the lowest level of benefits during the study period suggesting that they purchased less rich benefits.

And now this slide is only showing the most popular products. If we do look across the average of all products, the picture is slightly different. Mid-sized groups and large groups had very little changes in their benefits while small employers bought down their benefits more significantly particularly in 2008.

So now we will look a little bit at the non-medical expenses, the administrative expenses and contribution to surplus or profit.

So this slide shows the non-medical spending as a percentage of premium. We have broken down the non-medical spending into administrative expenses, commissions and contribution to surplus which is also referred to as profit.

In the administrative expenses we can see that small groups pay the highest percentage of premium for the administrative expenses -- about 7 and-a-half percent compared to roughly leave 6 percent for mid-sized and large employers.

This is likely due at least in part to the fact that some expenses are fixed in nature. So, for example, it costs the same amount to send out a bill to a small employer as it costs to send out a bill to a mid-sized employer but that small employer has fewer employees to spread the cost over. So as a percentage of premium, it costs more to administer a small employer group.

In terms of commissions, large

groups were paying just over 1 percent while the small to mid-sized groups were paying two to two and-a-half percent and we saw contributions and surplus in the two to three percent range during the time period.

That resulted in total non-claims expenses ranging from 9.6 percent for the large groups to 12.4 percent for small groups. So we do see that the small groups pay a higher portion of their premiums for these non-medical expenses.

This also results in loss ratios in the high 80s to roughly 90 percent which is higher than we typically see in other parts of the country.

The growth in the non-medical spending over the study period was quite variable.

From 2006 to 2007 we saw increases in non-medical spending for small employer with decreases for mid-sized and large and that trend reversed itself in 2007 to 2008 resulting in an average over the two-year period of increases of .3 percent for small groups and up to 4.3 percent for large groups.

So while small groups are paying a higher percentage of premiums towards non-medical spending, that non-medical spending was growing at a slower rate and, therefore, the difference in the spending between small groups and large groups actually narrowed during the study period.

I will show some preliminary results of the merged market. It was expected when the markets were merged which was effective July 1st of 2007 that individuals would realize lower premiums as a result and, in fact, we did see that as expected.

In 2008 individuals in the merged market were paying about a third less than individuals who remained in the pre-merger products.

Now, we can't attribute that entire amount to just merging of the market. It is also important to note that this incorporates the fact that individuals in the merged market are purchasing different benefits on average than those that remained in the pre-merger products and may also have a slightly different demographic.

Medical expense ratios by market segment -- again, we have seen that over the study period in total the loss ratios have been increasing and have been in the mid to high 80, 80 percent range.

Specific to the merged market we saw individuals in the merged market having a loss ratio in 2008 of 112 percent compared to small groups which has an 86 percent loss ratio. So this is suggesting that small groups as expected are to some extent subsidizing those individuals in the merged market resulting in a total merged market loss ratio of 88 percent.

This suggests that there is about a 2.3 percent impact on small employers of that subsidization in the merged market.

Finally, I will point out that all of the previous slides talk about average premiums and average premium growth over the study period.

Of course, not many individuals or small employers pay -- or large employers pay the average. There is a very wide range of premium amounts and premium increases that can be experienced in the market and there are several reasons for this.

For one, there are several carriers that were included in our analysis.

Some carriers will have different rate increases than others. Even within a carrier, they can make changes to their pricing.

For example, a carrier may change the rate increase for one given benefit plan in a different way than other benefit plans. In that instance, only those individuals or employers with a particular benefit plan that has been adjusted will feel that increase and there is also changes in the increase that are driven by demographics of the employer group.

So while we have reported premium trends of roughly 6 percent over the study period, that is really representative of their being little or no changes in the demographics of the population.

A small employer though, for example, if they have a fixed population and they have experienced no turn over during the year, we would expect that when they go to renew their insurance, everybody has gotten one year older -- typically there is 5 year age banding in premium rates -- so we would expect 20 percent of employees to be rated up into the next higher premium band.

That means if that if there were no changes to the population, instead of getting that average increase of 6 percent, we would expect the rate of increase to be over 10 percent as a result.

Other changes in the demographics can result in very different premium increases either higher or lower depending on the changes that were made.

And with that, I will turn it over to Deborah to talk about it claims analysis.

MS. DEBORAH CHOLLET: Good

morning.

As Stan Wallack has mentioned the examination of cost trends in this first year is focused only on privately insured plans.

The cost trends that I am going to discuss include both the covered benefits in a health insurance plan and the out-of-pocket spending by the insured employee or family of the insured.

The main take away points are here. I won't repeat them at the end but you can look to your copies to review.

Spending has increased quite quickly in Massachusetts at an average of 7.5 percent in 2006 to 2007 and another 7.5 percent from 2007 to 2008. That compares to national numbers that are substantially lower.

Spending for outpatient hospital care and physicians, other services professional services grew especially fast in Massachusetts.

We looked at the components of the

spending increases and prices drove spending growth especially for inpatient care and physician and other professional services.

In the outpatient setting including outpatient imaging, the spending growth was driven by both volume and increase in the number of services provided and price.

Prices varied widely for all of the services we looked at. We looked at major services in various categories and we saw substantial price variation.

And finally we looked at hospital readmissions which the Division has looked at before and what is different about what we have done is that we also looked at physician visits within 30 days following readmission and so I will present those general findings.

As I mentioned health care costs rose at 7.5 percent in each year we looked at. The national average growth was something less than 4 percent. This is as close as we can get on a system basis.

So Massachusetts is well above the

national average. This left Massachusetts in 2008 with a privately insured population paying about $4,500.00 per member per year in Massachusetts which is quite high.

And, as I said, that includes both the insured and the out-of-pocket costs. Physician and professional services and outpatient care in Massachusetts represents combined 57 percent of total spending in 2008.

When you add prescription drugs in at 18 percent and inpatient care at 17 percent, those four categories of services combined cover about 92 percent of all spending in Massachusetts.

I will come back to that because in fact those categories, the largest categories of physician and other services and outpatient hospital care are also the fastest growing which you see in this slide.

I think what is important about this slide is that not only are outpatient hospital and professional and physician professional services rising faster than the average in Massachusetts. They are rising at an increasing rate, that is costs in effect have accelerated in 2007 to 2008.

The other important thing to notice is that the only reason that health care spending was as low as it was in Massachusetts and growth was as low as it was was the very slow growth of spending for prescription drugs -- largely related to the adoption of generic drugs and utilization.

Absent that pharmacy trend which is you will recall from an earlier slide which is the third largest sector of spending growth, on the average overall would have been much faster and health care costs growth in Massachusetts would have accelerated as opposed to having that even 7.5 percent from year to year.

I am going to go through the three categories of services -- hospital inpatient expenditures, physician and other professional services and outpatient expenditures including imaging services -- now I am thinking about it, not necessarily in that order.

Hospital expenditures increased about 9 percent from 2006 to 2007 and about 8 percent from 2007 to 2008.

The fastest growing segment of those expenditures were for medical inpatient admissions -- second to surgical.

You will notice that there is a large drop off in growth for maternity and newborn care and, again, the moderation of spending in inpatient services was largely related to that maternity drop off and I think we can discuss what that is about if you wish.

But absent that, the overall growth would have been higher and the slow down in inpatient spending would have been much less.

Despite the fact surgical admissions, the expenditures for surgical admissions grew more slowly than for medical admissions. Those surgical admissions are very expensive. They represented more than half, 52 percent of the growth in inpatient care.

I am going to take a little bit of time with this slide because you will see a series of others that are similar to this. We created a market basket of spending for each of these service types.

The market basket that was created in 2006 and 2007 because there was a bigger claims tail in the later year.

And when we were looking at services at this level, we could not adjust for that claims tail but the other spending numbers do adjust.

We have no reason to believe that the 2007 to 2008 pattern is much different from this.

This market basket includes services that were delivered consistently from year to year so there were no new services popping in and there was a large sample of new services that we could look at.

The market basket from 2006 to 2007 included over 90 percent of expenditures for inpatient care. We then divided out the impacts of three items on total expenditures that is how much of the growth was driven by increases in prices, how much of the growth was driven by increases in the numbers of admissions for those particular services and how much was driven by the fact that the service mix was changing -- that there might have been more complicated services delivered in 2007 that had been delivered in 2006.

And you will see the result is price. There is no increased admissions -- to the contrary -- there was a drop off in admissions -- there was no increase, no significant increase in the complexity of services delivered -- the difference was in price.

Now price itself is a relatively complicated variable. It includes not only the provider in place simply increases prices -- it certainly includes that but it might also include some movement in the system. It would include patients who are seeking out higher priced providers and in this case higher priced hospitals and that would have generated an increase in the prices that we observed.

It could also be changes in covered lives among carriers that happen to pay providers higher prices. It is likely to be mostly the first given that there is not that much movement from year to year either in going to different types of providers or moving from insurer to insurer.

Outpatient expenditures you will see that the increase in outpatient expenditures not only is high, but that the procedures in imaging, in particular, account for more than half.

I think the increase in expenses for imaging services has been somewhat of a surprise in Massachusetts.

Sixty-three percent of the growth in spending for outpatient services is associated with this bottom green bars that is teaching hospitals. But teaching hospitals represent overall just 54 percent of expenditures for outpatient services.

So teaching hospital growth is significant with respect to the outpatient trends.

This is the same kind of slide we have spent sometime on a minute ago taking outpatient service growth and looking at what the impacts have been of price, the number of services delivered and the service mix and you will see that it is both price and the number of services that was driving spending for outpatient services.

Did I skip over something? I am a slide behind, I apologize.

I am going to move on to imaging services and expenditures for imaging services.

You will see that the standard imaging is the largest component and also the fastest growing component in 2006 to 2007 followed by echographs and ultrasounds. That pattern reversed itself somewhat in 2007 and 2008 and MRIs, MRAs became the fastest growing component of outpatient imaging.

What we are looking at here by the way is a combination of the professional services and facility charges.

The drivers of spending growth for imaging services again looks very much like overall outpatient -- the combination of price and the number of services provided and there is not an increase in the complexity of services provided.

We move on quickly to physician and other professional services. You will recall physician and other professional services is the second fastest growth category after hospital outpatient in Massachusetts.

The growth in spending for physician services in particular reflects fast growth in spending for specialist care. Spending for primary care slowed somewhat from 2007 to 2008.

While specialists services were not growing the fastest in these years, they do represent growth in spending for specialist services represents more than half of the growth in this spending category overall.

In 2007 to 2008, 48 percent of the growth in spending for physician and professional services -- again drivers have changed looking at the contribution price, the number of services, the number of service mix or the amount of changes in service mix, and you will see, again, price is the primary driver of spending growth in this category.

We looked at a couple of opportunities -- potential opportunities for improving efficiencies in health care in Massachusetts and particularly we looked at price variations as an indicator of provider market power and in economist's terms, market failure, failure of competition to constrain prices -- you will see this talked about in other points during the day as leveraging market power.

We also looked at these avoidable hospitalizations. A half minute on this slide you will see a number of others that look similar in the technical report.

The top of the arrow is the highest price we observed once we cut off the tail. So we look at the 95 percentile of prices paid for the same DRG across all hospitals and across all payers with the six large insurance carriers in Massachusetts.

The low price, the bottom of that arrow was the lowest price at the 5th percentile.

Again, we cut off the tail so the distribution we observed is actually larger than this. And the price you see indicated there is the average price.

So you see the variation here that we are looking at. The variation for the same DRG is 2 to 1 -- an enormous difference. You see the same thing for outpatient services and even more variation in spending in outpatient services both in hospital outpatient settings and in free-standing clinic settings.

The same variation in physician and professional services -- the lowest price paid is -- we should reverse that, the highest price paid is orders of magnitude greater than the lowest price paid for the same service.

And, secondly, we look at readmissions. As I said, Massachusetts has looked at this issue of readmissions before and I think two things are important to take away from this.

First of all, the rate of readmission, all causes readmission within 30 days is relatively high and it, in fact, adds almost $50.00 to expenses per member year in Massachusetts simply the costs of a readmission within 30 days.

63 percent of readmissions are to teaching hospitals in Massachusetts.

What is different about what we have done in this study is to look then at whether we could find a physician visit within 30 days of discharge and what difference that made and we found that, in fact, it made a difference. It is all cause. It is not adjusted for risk and that suggests to me that if we did adjust for risk, we would find even higher disparity that we would find.

73 percent of index admissions that is that first admission we could find when it was followed by a physician visit resulted in no readmission.

In teaching hospitals we found that there was a lower probability of a physician visit within 30 days and a higher probability of readmission.

To the extent that there is sufficient is primary care or follow-up care following a hospitalization, it appears that there is a substantial opportunity to reduce costs.

PROFESSOR STANLEY WALLACK: Thank you.

Let me start asking some questions. You all spent a good amount of time doing the study over the last year and there was a lot of work to do and thank you for getting it done.

But looking back at it now, I

guess, the first question I ask each of you and maybe we will start with Cindy, what was the most surprising finding on your part of the study and, secondly, I guess, what would you want to know to validate it?

I mean so what were you surprised with, Cindy?

MS. CINDY PARKS THOMAS: Well, first of all, I was surprised that national data don't exist beyond 2004 to compare any state to the nation beyond which created greater challenges for us to understand where Massachusetts is in context but beyond that I think we all knew going into this the strong presence of an academic center driven system, however, the scale at which it was -- it dominates was a pretty big surprise to me.

The second thing is this issue of outpatient services moving into the outpatient care area, changing the footprint of outpatient care being delivered by hospitals and which hospitals is I think pretty important and would really warrant more -- I think warrants future investigation.

PROFESSOR STANLEY WALLACK: Dianna?

MS. DIANNA WELCH: I guess I will start with what I think warrants some more investigation which would lead to the surprising part but really this issue that I addressed last of the variability between the rate increases I think it would have been -- it would be great to study that further in the future to get more information about how wide the variability is.

We really only have the ability to look at averages in our study and so I think it would be interesting to look at that I guess because of some of the surprising premiums trends that I was a little surprised that we didn't see trends higher or at greater disparity than what we found between the market segments.

PROFESSOR STANLEY WALLACK: Thank you.

MS. DEBORAH CHOLLET: I think the surprising thing and I agree with Dianna also I think the area that more investigation is warranted is in the dominance of price in driving overall expenditure growth especially for inpatient and physician professional services.

And then the role of price variation in that process of expenditure growth -- the amount of price variation was astonishing frankly but not surprising given how prices are set, but that being said, when there is that much opportunity to find a lower cost provider, one has to wonder what systems might be put in place to help both consumers and employers find lower cost providers.

They may be paying relatively low deductibles but they are also paying co-insurance and the lack of opportunity to find a lower cost provider and understand whether there may be potential quality is difference is, I think, is a key in controlling costs.

PROFESSOR STANLEY WALLACK: Thank you. Good answers.

For those of you who haven't read the stack as someone described of the reports, there is a lot in there and I think I appreciate you coming up with sort of the highlights and then these couple of points.

But Cindy an important finding that you didn't highlight here -- it was in the contents paper so all of you should look at it, again, Part 1, was that although you adjusted and showed we were 27 percent higher when you did the adjustments for revenue and wage, you came to Massachusetts is 15 percent higher. There is also a really interesting graph, diagram in the report that shows while Massachusetts spends, you know, at a high level, 13 percent, when you compare this to states at similar income levels, we are sort of in the middle and you didn't bring that up but I think it is, again, this context of what is good, how do you do that and what do you have to say about it?

MS. CINDY PARKS THOMAS: Yes, that is an interesting point.

We are kind of in the middle but I would say that health care costs are a challenge for all states and we can find, we are not unique in that way.

We need to address these challenges, but there are states that have an efficient system that we didn't talk much about yet and we will over the next few days that have found a way to have a lower portion of their state product going to health costs -- they have found more efficient ways to provide care.

There are opportunities and other states and systems have found that.

PROFESSOR STANLEY WALLACK: I want to go back, Dianna, to what you discussed which is sort of the volatility issue, because I think that the actuarial kinds of simulations, aspects that you made was interesting.

But I want to ask you a question given also your experience at Blue Cross and being in the trenches there and not being a consulting actuary about how those really do translate -- how those variations that you have pointed translate into actual premiums that firms are asked to pay.

I was talking to a small business owner in Fall River last Friday and he said he was happy he only got a 15 percent increase, okay?

But he was also surprised because he said that the two oldest workers or the two people over 60, he let go, they left his insurance policy. So he thought his rates, in fact, should be adjusted down and when I looked at the volatility, and I know you always see the bad stories, the ones that got 15, 20, 25 percent but we would expect to see in the analysis some people having decreases or very low increases.

So I wonder if you could sort of explain. I mean I said I was an economist but I was going to meet with an actuary on Monday -- I had asked her to sort of explain to me do insurance companies when they look at those demographics and demographics which should really drive down the premiums, how do they deal with that when they set the rates?

MS. DIANNA WELCH: Well, if you are talking specific to the small employer market there are ratings limitations in the market here that constrain what the insurers can do.

It also requires that every small employer of similar characteristics has to be treated similarly. So the insurers are not looking employer group by employer group and setting the premiums, they have to use consistent factors in setting those premiums.

So every small employer who drops, you know, loses a 65 year old worker and picks up a young worker should see the benefit of that in their rate. Of course, in any given rate renewal there is so many moving pieces. There could be changes made to the benefit plan design that they had. There could be changes made to the size of the group that effect the increase. There could be changes in age. You know, there are many things that effect it. The carriers could be shifting their pricing of how they evaluate a different area adjustments.

So in anyone given renewal for any given employer there are many, many different factors that play into the final premium all of which ultimately have to be within the rating limitations of the state.

PROFESSOR STANLEY WALLACK: So you think if we actually did the survey with all firms we would find some decreases maybe?

MS. DIANNA WELCH: I would think that there should be a wide range.

There will be some large increases and there should also be firms out there that would receive decreases if they have gotten younger since the last renewal.

PROFESSOR STANLEY WALLACK: Deborah, the overall growth expenditures that you showed, hospital outpatient facilities were really increasing, but you also showed -- you showed in your graph that free-standing facilities -- you also showed those but what you didn't go into in this discussion, what you did go into in your larger paper was we have seen a change. We sort of have free-standing facilities actually decreasing overall and sort of the outpatient facilities, a portion of care there actually going up.

Do you have any sense about what is going on from digging deeper into the analysis of the kinds of services or why we might be seeing that -- the shift between free standing and outpatient hospital facilities?

MS. DEBORAH CHOLLET: No, the data don't really give any indication of why we might be seeing it but there does seem to be a transition away from the use of free-standing facilities to hospital outpatient departments.

The services that are being offered in hospital outpatient departments aren't necessarily much more expensive than were in free-standing facilities -- they are somewhat more expensive and as I mentioned before the variation in both free-standing facilities and outpatient facilities is very large.

What is driving that transition from one to the other out of free-standing facilities into Outpatient Department isn't apparent.

PROFESSOR STANLEY WALLACK: I am going to take one of the questions from the group here and it is a question dealing with teaching facilities -- both I think on the outpatient and the inpatient side, and why is spending going through the high teaching hospitals, who or what is steering that activity to teaching facilities?

You described in your analysis that you were seeing, one of the reasons and I think in some of the responses from the insurers, they said if you look at the price increase, you know, maybe 25 to 30 percent of it is as a result of these shifts that are occurring between providers.

So there is more care in your analysis outpatient and your analysis of inpatient in the report -- more care going to teaching facilities.

Do you have any idea? The question was who or what is steering the activity to teaching and academic hospitals?

MS. DEBORAH CHOLLET: I think the answer is that no one is really staring it. I think what you are looking at is non-exclusive networks where the teaching facilities are included in the network as well as the non-teaching facilities and that leaves it up to the patient to make the decision and maybe the patient's physician obviously to make a decision about whether the patient goes for inpatient care and with respect to outpatient care, it is likely to be reputation of the facility -- whether the reputation is, you know, warranted or not warranted for the particular services that the patient is seeking.

PROFESSOR STANLEY WALLACK: One

of the things we didn't have time to do -- yes, that is right -- one of the things we didn't have time to do was to really look at the effect on these growing networks between the hospital and the physicians and I think maybe the person asking the question was asking about what hospitals are being used as these hospital physician networks actually get larger.

This is a question just brought to be which I will read. It is around payment reform and one of the issues -- I will paraphrase the question -- when we look to payment reform and we looked at some global payment of capitalization what we are trying to get at is changes in utilization -- move care to less expensive settings but given your analysis today of price being the major driver is your focus on the -- is the focus on fee for service misplaced or the focus on global capitation misplaced?

Interesting question, thank you.

MS. DEBORAH CHOLLET: I don't think the focus on greater bundling of services is necessarily misplaced but I think what has to occur or what would be beneficial if it occurred would be a greater rationalization of the system.

So even if you have a bundle of payment, you have to establish a level of payment and that level of payment needs to be rationalized and it needs to be premised more clearly on the value of the service and the efficiency of the location of the service.

I think the idea of bundling payment is that that is done internal to a decision process by a provider group -- and not done externally via regulation.

But it is appears that even when payments are bundled currently -- that is when we are seeing capitated payments -- the same apparent irrationality of payment persists.

We saw no evidence that a capitated payment amount was substantially less than an uncapitated fee for service payment amount.

So, overall, the rationality of the system needs to be improved regardless of whether the services are bundled or paid fee for service.

PROFESSOR STANLEY WALLACK: And also you had mentioned in the contents paper, one of the things that was mentioned was that when we saw the growth -- of course, we had regulation for prices in the '80s, it turned a curve in '91 -- once you saw managed come on people thought managed care could bring down prices and bring down premiums and they did and I think there was excess hospital beds and I think Cindy was showing some of the shifts that went on as small hospitals closed, we had more teaching hospitals.

We have changed the balance, I think, over the last ten years between providers and payers and I think one of the questions we are pursuing over the next couple of days is who has leverage in these negotiations and I think that that is an issue as well.

I think whoever is asking the question is probably thinking about how has the marketplace changed here and we have to have a very comprehensive approach.

I have a question -- I am going to turn to a question that I have for Dianna. I will give you one.

One of the questions that I found interesting and I found most surprising perhaps about your analysis other than the volatility question that somebody asked me about was actually the very small difference in the administrative -- the loss ratios or the administrative costs between the small groups and the medium-sized groups and the large groups wasn't very large and I have always thought from reading national papers that the small groups have these very large brokerage commissions and, therefore, the administrative costs are much higher and your results don't show that.

I wonder if you could explain that.

MS. DIANNA WELCH: They don't show that there are significantly greater commissions in the small group market.

That may be something that is a little unique to Massachusetts. If I think if we were to look outside of Massachusetts, you might see some higher commissions being paid in the small group market and in particular in the individual markets outside of Massachusetts typically have much higher commissions whereas here the individuals are now merged within the small groups and we do see lower commissions here.

The other things that we have seen that was highlighted is the narrowing of that gap in non-medical costs between the small employers and the large employers over the study period so when we look back a couple of years, that gap was wider and health plans have reduced that gap just recently here in the last couple of year years.

PROFESSOR STANLEY WALLACK: Cindy, I have a question to you and we will go back to some questions from the audience.

Cindy, what you reported on the

context paper, there seems to be little distinction between HMOs and PPOs and I am wondering if -- that was another surprising finding that they are all paying fee for service. So if we did a PMPM -- we just pressed per member per month -- what do you think we would find?

We have all heard about HMOs being more efficient in terms of driving down costs and utilization -- do you have any sense with that.

MS. CINDY PARKS THOMAS: Since we are dominated by large networks, I would imagine there may not be much difference between the HMO or the per member per month cost.

PROFESSOR STANLEY WALLACK: Let me ask one question -- I have a final question -- let me ask -- I have a couple of minutes and I am done? Okay.

So I have a question here and if anyone wants to take it on, I won't aim it at Deborah, but if anyone wants to take it on -- but the question is please discuss the impact on increasing private insurance costs and provider costs for hospitals with high Medicaid and Medicare patient mixes and are underfunded public payment rates.

We could leave it for another panel.

Did any you of want to take that on?

MS. DEBORAH CHOLLET: I have not looked at that issue in Massachusetts but I have looked at it in other states and I would hazard to guess that the pattern is consistent here.

There is cost shifting where the market allows cost shifting to occur.

So when we look, for example, at competitive markets where there are a number of hospitals, a number of physicians that are competing, we don't see any relationship between the rate at which the public payer is paying and the rate that the private payers are paying. You don't see that cost shift. You don't see an increase in prices associated with the failure of the public sector to increase prices overtime.

But in markets where providers have market power, where they have leverage, you will see an increase in private payer rates associated with that.

So, in general, if I as an economist assume a revenue maximizing institution or a revenue maximizing provider and there is no constraints on maximizing revenues, that is pretty much what happens.

So the cost shifting story is somewhat complicated. It is driven by competition and the kind of hydraulic approaches -- whatever Medicare and Medicaid don't pay private payers pay simply doesn't pan out.

PROFESSOR STANLEY WALLACK: Again, as we study, as we learn more by doing Medicare and Medicaid, I think we will learn more what is certainly going on in this state and we also have the power of that provider, the private payer wanting to know what that market looks like. We also have the numbers.

If you are a private insurer you are not sending a lot of people to this facility -- that may have an effect on negotiations as well -- what the importance will be for the private payer to pay the higher rate.

So let me ask my last question. I could go on. Believe me, there is a lot of stuff here.

Let me ask another question and it has to do with this outpatient issue because I think -- outpatient hospital facility issues -- so we recognize in this state and it is certainly documented that we have seen this tremendous growth in outpatient hospital facilities and it is one that is growing fastest relative to its baseline that Deborah showed us. Now that growth can be looked at positively if we are taking expensive patients out of the inpatient setting and putting them into a less expensive setting that is positive.

If, however, we are seeing the outpatient facilities grow and care is moving from the less expense facility physician's office, we are paying for the higher facility costs for these outpatients.

So I would like each of you from your experience in other states or from your experience in sort of just generally in health services to tell me whether you have any sense of what is going on here -- is it a good thing or a bad thing that we are seeing this tremendous amount of growth and is it something that we should sort of -- people should be thinking about in this state with regard to DON -- is that what it is -- with regard to outpatient facilities.

Cindy, do you want to start with that?

MS. CINDY PARKS THOMAS: Yes, I think that -- I don't believe that the flattening or decreasing growth in hospital admissions is really commensurate with the increase in outpatient services.

I don't think many of us believe this is true. We are substituting outpatient for inpatient -- that may be happening to some extent but I think as outpatient facilities expand particularly in a teaching hospital, it is an attractive setting for physicians to provide care.

I know, for instance, physicians providing cancer care are now providing them in hospital outpatient settings to a greater rate than with the change in reimbursement particularly by Medicare -- I think that hospitals as they are interested in expanding these various areas, I think they are quite attracted to physicians to provide care in those settings without having to overpay.

PROFESSOR STANLEY WALLACK: That is just conjecture?

MS. CINDY PARKS THOMAS: Yes.

PROFESSOR STANLEY WALLACK: A lot of outpatient cases with these new cancer infusion drugs -- Dianna?

MS. DIANNA WELCH: I don't have anything to add on that.

PROFESSOR STANLEY WALLACK: This driving costs that you have seen in any other states? Is that unusual?

Cindy showed we are very high and is that something that we are seeing happening?

MS. DIANNA WELCH: I wouldn't say it is unusual to see high trends and in particular high trends in the outpatient. Anything beyond that is --

PROFESSOR STANLEY WALLACK: Thanks. Deborah --

MS. DEBORAH CHOLLET: I think there are two ways to look at this.

No. 1, I think avoiding a hospital inpatient admission is a good thing on the whole simply because of the dangers of an inpatient admission -- that the patient does not control that environment and we know from substantial research that there is a risk of injury and infection in an inpatient environment that might not exist in an outpatient environment.

However, it is hard to control costs in an outpatient environment for the same reasons that a regulator is not much in control of that situation. Providers and patients are in control of that situation.

And I think that that is the reason that we are seeing both an increase in price and the increase in the volume of services driving costs in that sector.

It is very hard for a regulator to get their arms around an outpatient environment. We see that even in states, for example, in Maryland and West Virginia that regulate inpatient hospital rates.

They are also seeing fast growth in outpatient expenditures because they haven't regulated them in the same way.

PROFESSOR STANLEY WALLACK: It is an opportunity to talk about global capitation to rationalize that system.

We have a very hard time with the outpatient side relative to the inpatient side.

I am reminded of one of the readings I gave my students in class -- as a Professor, I give a lot of reading to keep them busy, but one of the readings was

The Hospital is a Doctor's Workshop but is a an older article. Why is it something from -- I won't say the year -- but probably something from the early '80s or late '70s, it sounds to me one of the answers that Cindy is giving us -- that a lot of the ways the hospital outpatient facility has become in some ways a really good place for a physician to do practicing for a variety of reasons that enables them whether it is imaging or cancer infusion drugs.

It is important thing for us to learn a lot about. Because it may be higher quality as Deborah said, but it is really where the costs are being driven.

So I think as you get your agenda ready, David, for going forward, that is certainly an area that I think you want to concentrate on.

So thank you to the panel and I hope we all learned something.

(Applause from the Audience.)

COMMISSIONER DAVID MORALES: Thank you, Professor Wallack.

Two very quick things -- one, I would like to invite Chairman Jeffrey Sanchez, Chairman of the Joint Committee of Public Health and the House of Representatives to offer brief remarks and then we will take a short break.

(Applause from the Audience.)

REPRESENTATIVE JEFFREY SANCHEZ: Good morning, thank you so much, Commissioner Morales and members of the panel, thank you for your insight.

Again, I want to first of all thank you for inviting me to make a brief statement before the panel.

All of us know and we knowledge that our system is fundamentally flawed. We have to try to figure out how we go about despite our success how we make our health care system responsible accountable and make sure that the system are working for everyone.

Not only that we have but we have to do it in an environment that brings down our costs and improves quality.

We have been able to do so much through Chapter 305 that included proposals to increase transparency and health care spending and improve our public reporting of patient outcomes and more demanding of patient safety protocols.

305 also established several collaborative efforts to realign our health care delivery models to fit a more modern patient centered approach to care.

Now our task is to build upon Chapter 305.

In my time as the House Chairman of Joint Committee on Public Health, I have met with many of the stakeholders who will address this panel over the coming days and they all have a unique and informed perspective on the contributing factors to the current crisis facing the Commonwealth.

What we do not have is a consensus opinion on where the problems lie and how to address those problems and that job of building that consensus falls to us.

Our task as public officials is to weave individual perspectives in a coherent public policy that will provide a positive lasting benefit for all of the people of the Commonwealth and, yes, businesses as well.

And to achieve this lasting and comprehensive solution to the problems plaguing our system, I would suggest that this panel and those who appear before it expand inquiries beyond the traditional questions of health insurance and payment reform while I enjoin the dialog and discussion on variables and market failures and all of those great terms that the average citizen, you know, tries to understand and, you know, especially when they are hearing them from us -- we have to try to make sure that, again, we look at the lack of emphasis on preventative health policies.

For far too long we focused on the financial side of getting care to the sick to the solution of where we should exert our efforts to prevent sickness and disease.

Asthma, heart disease, diabetes and other chronic illnesses are preventable and treatable and our health policies must be aimed at curbing the effects these conditions have on the public health and the bottom line.

Less than 5 percent of all of our health expenditures are spent on prevention and wellness efforts -- yet for every dollar spent on initiatives to increase physical activity, improved nutrition and prevent smoking, a total of $5.60 can be saved in health care costs.

Preventive health policies and new efforts to educate citizens on the importance of making healthy choices must be an integral part of any health care savings initiate.

Another aspect of public health policy that would be crucial in any successful effort to reduce spending is the ongoing effort to eliminate disparity and access to care for vulnerable populations especially those who are in underserved areas of the Commonwealth.

Our health care reform is an empty promise if we do not address the barriers of care and disparities of access that still remain despite our success in providing near universal health insurance coverage.

And we cannot ignore the economic fact between 2003 and 2006, 30.6 of direct care expenditures for African Americans and Asians and Hispanics were excess costs due to health inequalities. Examining the matters that have been brought before the Joint Committee on Public Health there are other contributing factors to our health care financing crisis that we should also be including in the discussion on cost control and health care reform.

For instance, the continuing evolution of education and training standards for health professionals that support our physician community should lead us to examine how we better use each member of the health care team to maximize the effectiveness of patient care and foster better patient outcomes.

Reducing health care spending will require us to make sure that public policy utilizes all of our health professionals education and training to provide care to patients in a way that bought maximizes their skill sets and reduces health costs to patients.

Professional services such as advance practice nurses, clinical technicians, community health workers and non-traditional care providers must be a part of this dialogue to ensure that patients have increased access to well trained and qualified providers who are able to -- who are able to with their educational standards and scope of practice without outdated or arbitrary restrictions on their practice.

We need to ensure the smooth integration of health records and new technologies and do so in a way that extends the benefits to all providers and we need to also coordinate patient care to the spectrum of health care providers to reduce duplication of treatment and improved outcomes and prevent medical errors.

Also, in the committee, we have also looked at general administrative and oversight capabilities to identify structural inefficiencies in the delivery of healthcare to try and look at wasteful spending.

I know that I share the view of my legislative colleagues that the road ahead of us will not be easy but that we must act now to stem the tide of unmanageable health spending increases for Massachusetts families and businesses.

I look forward to working with members of the panel and forging ahead with the next steps.

I have taken enough time. I thank you so much, Commissioner and I thank you members of the Panel.

(Applause from the Audience.)

COMMISSIONER DAVID MORALES: We are going to take a very brief three-minute break and we will be back here at 11:25.

(Short Recess.)

COMMISSIONER DAVID MORALES: Thank you.

I would like to ask Commissioner Murphy to approach the podium for the next presentation.

COMMISSIONER JOSEPH MURPHY: Thank you, Commissioner.

I am Joe Murphy. I am the Commissioner of Insurance and I am joined here today by Kevin Beagan who is our Deputy Commissioner for our Health Care Access Bureau.

We appreciate the opportunity to join you here today.

Today I would like to give an overview of the small group market and also talk about the review that we have undertaken of recent small group rate increases.

At the most basic level health

plans provide or arrange payment to providers for covered services to insure individuals for employer groups. The delivery of health care and the administration of health insurance coverage has been become more complicated over time because doctors, hospitals and other providers have access to effective techniques and services that could not be imagined 20 years ago.

We as consumers of health care expect our health plans to pay for these services when we need them.

The American market is more complex than other systems because of the level of choice. Large and small employers, employees and individuals can chose from a variety of health plans offering different benefits, cost sharing and provider systems. The greater the number of choices the more complicated the system and its administration.

As the complexity increases, higher costs and inefficiencies follow.

Beyond the differing level of health care benefits, Massachusetts residents expect the right to go to their doctors and hospitals when they need them. Unlike many other states the major Massachusetts health plans have created networks that include almost all of the same providers whether they are high cost or low cost.

Massachusetts residents have intimated in comments to the Division and complaints to health plans that a plan is inadequate if it does not have access to all of the providers that people want when they need them.

Over the past half century the government, private businesses, employers, consumer advocates and health plans have tinkered with the levels of choices as to networks have tied to implement point of service systems and tiered arrangements and health savings accounts and have utilized managed care tools in consumer education in an attempt to impact choice and provide incentives for covered persons to get the appropriate level of care.

Health care costs and health premiums are continuing to rise at alarming levels despite the actions described above.

According to a report issued by Oliver Wyman for the Division between 2002 and 2006 the total costs for medical services per insured member per month increased by 55 percent for an average increase of 11.6 percent per year.

Some claim that costs have increased at higher rate for small employers offer the past few years. As employers and individuals are forced to pay high prices, these increases threatened to strangle businesses efforts to recover from the most recent recession.

In August of 2009, Governor Deval Patrick charged the Secretaries of Housing and Economic Development, Health and Human Services and Administration and Finance to explore and evaluate all reasonable options to address the rising cost of health coverage impacting Massachusetts small businesses.

The Secretaries detailed ongoing efforts being conducted through their own agencies and through the health care quality and cost counsel to restructure the method of paying providers and to simplify the administration of health care services as well as additional items that needed immediate review.

On October 20th, 2009, among other actions, Government Patrick directed the Division of Insurance to schedule informational hearings to examine health care premium increases concentrating on small group premium changes and actions that companies are taking to address costs.

During this time the Division invited each small group health carrier as well as hospitals and providers groups to explain their own systems and the reasons that the costs were increasing.

The Division held introductory hearings in the first week of November in

Lowell, Springfield, Boston, Bridgewater and Worcester to listen to public comment on the questions upon which it should concentrate.

Over the next seven weeks the Division instructed the ten health carriers participating in Massachusetts small group health insurance market to respond to a series of questions regarding the following topics.

Week One -- company cost containment initiatives. Week Two, health benefit design, marketing and administration. Week Three, consumer services, financial systems and regulatory affairs. Week Four, general management expenses and claims payment systems. Week Five, provider contracting and network management. Week Six, utilization management and claims payment trends. Week Seven, premiums development for whole plan and smaller groups.

In addition to the health plan hearings, the Division invited each of the state's hospitals and health care provider trade associations to attend hearings between January 7th and January 12th to provide testimony or submit materials in written form.

Over the past two weeks we conducted a second set of hearings across the state including stops in Boston, Fitchburg, Framingham, Hyannis, Lawrence and Pittsfield.

We have collected reams of information through this hearing process and also through our confidential examination authority.

The Division was directed by Governor Patrick to examine information presented in these hearings that propose changes that may be implemented in statute, benefit design or administrative practices to mitigate the substantial annual increases that have impacted the small group market.

On February 10th the Governor announced the jobs package that includes both regulatory and legislative efforts to assist small businesses with their health insurance costs.

On the regulatory front the Governor directed the Division of Insurance to issue an emergency regulation requiring carriers to file their proposed small group rates at least 30 days in advance starting with those with 4/1/2010 effective dates.

Carriers are now also required to file substantial documentation to support their proposed rates.

DOI is reviewing this information and will determine if the rates should be disapproved. The legislative components of this package include soft caps on insurer and provider rates for a period of two years and legislation that will provide for more affordable options in the marketplace.

According to reports developed by the Division of Insurance as of December 31st, 2009, a total of 815,931 persons were covered under small group health insurance plans including 72,513 individuals and 743,418 covered through small employers.

The Massachusetts market for small

group health insurance is dominated by coverage offered by the state's health maintenance organizations which account for 87 percent of this coverage.

The remaining coverage is predominantly with Blue Cross and Blue Shield's non-HMO plan, the Assurant Health Insurance Companies and other insurance companies who are no longer offering coverage.

Among the HMO plans, the statewide plans offered by Blue Cross and Blue Shield, HMO Blue, Harvard Pilgrim Health Care and Tufts Associated Health Maintenance Organization account for over 85 percent of all HMO membership.

Unlike the markets in many other states, the Massachusetts market is dominated by Massachusetts centered nonprofit health maintenance organizations. The four largest plans grew from regional health plans to statewide plans that operate in limited other jurisdictions.

The large national health plans,

United Health Care of New England and Aetna which have substantial presence in other states account for less than 1 percent of the Massachusetts small group health market. The four largest health maintenance organizations each offer robust provider networks that include the vast majority of hospitals, primary care providers and specialty physicians that are available throughout Massachusetts.

Although there are minor differences in the service delivery systems of the providers under contract in each plan, in general the networks each offer approximately the same access to hospitals and physicians throughout the state.

These health plans do not compete at this time based on access to providers but instead strive to have network that are similar to their competitors so they will not lose any competitive position to the others.

In the one year period between July 1st, 2008 and June 30th, 2009 the largest seven health maintenance organizations collected 13.8 billion dollars in revenue from premiums and fees generated from serving sell-funded accounts.

Revenue generated from small group health plans accounted for 3.2 billion dollars during this period. During the above noted one-year period large group premium revenue accounted for almost half of all revenue generated by the health plans.

Small group premium was smaller but still accounted for over 23 percent of total revenue.

If government revenue were excluded, small group premium revenue would account for over 30 percent of all revenue generated by the largest seven HMOs.

As noted previously, the companies in the Massachusetts market compete aggressively to maintain and grow their shares of the market.

In the large group market carriers experience rate based on each large employers prior and projected medical expenses compared to other large groups.

In the small group market carriers are required to base rates based on the prior and projected medical expenses of the overall small group market with adjustments based on the age, industry, participation rate and location of the group.

In response to claims that small group rates were increasing more rapidly than those of the large group market, the division looked more closely at the overall trends in April of 2009.

At that time certain companies did increase rates more for small group than for large groups.

For example, Blue Cross and Blue Shield of Massachusetts raised the base rates for its two most popular small group plans by over 14 percent while keeping rates for its large group plans to under 10 percent.

We hope to issue a report on our findings as a result of all of these hearings within the next month, however, I would like to share some preliminary findings from our report.

The top HMOs, Blue Cross and Blue Shield, Harvard Pilgrim and Tufts Health Plan cover 87 percent of those enrolled in HMOs. Each is a local nonprofit contracting with over 65 hospitals, 4,000 primary care doctors and 16,000 specialists. On average, 85 to 89 percent of each premium dollar is spend on health care payments to hospitals and other health practitioners. The remaining amounts are devoted to administrative expenses or contributions to surplus.

It is becoming more complex to administer plans due to three main issues -- one being provider networks.

Network hospital and non-hospital providers have increased reimbursement demands to pay for technology, training and capital expansions as well as to subsidize underpayments from government and other creditors.

Second, employer products --

employers have increased demands to reduce benefit costs while maintaining the same level of health benefits and are exploring a wider array of cost sharing and tiered network plans.

Third, regulatory constraints, plans need to devote resources to design health plans and rates and responding to consumers, contract with providers, develop utilization review and cost containment programs and pay claims and report to financial and regulatory agencies and develop information technology systems to keep up with this complexity.

Another finding was the increase in complexity causes inefficiency and raises costs to all.

Small group and large group premiums are both growing but small group premiums are growing at a faster rate.

Small group administrative costs are higher than those of large employers mostly because HMOs perform many more enrollment functions for small employers and need to spread certain account level costs over a smaller pool of employees.

Small group utilization is higher than utilization for large employers. Individuals are allowed to jump into coverage when they need it to pay for health services and jump out after this treatment is provided.

Large employers are much more likely to employ health management or wellness programs that address employees who are at risk of developing chronic health conditions.

The following options were raised during the course of the hearings to help carriers decrease the cost of coverages to small employers. Again, these are options, not necessarily recommendations and they will be more fully discussed in our report to be issued later this month.

Under the heading of creating more affordable small group products, some of the options we have heard or explored include requiring the marketing of plans through all distribution channels; the requiring the offering of one product -- at least one product -- that does not meet MCC levels, requiring the offering of at least one selected network product; permitting the offer of coverage through group purchasing cooperatives; permitting health plans that exclude mandated benefits; permitting carriers to offer at least one tiered benefit product where doctors may move from one benefit tier to another during the contract period; requiring a plan whose provider rates are capped. This is also known as the affordable health plan legislation.

We also heard a lot about making adjustments to the small group rating rules and under this heading some of the options we are considering include allowing the Commissioner to annually adjust rating rules to eliminate duplicate or unwarranted costs; eliminating age rate factors; capping the application of rating factors to reduce shock when group composition changes;

smoothing rate factors to reduce rate shock; allowing carriers to offer wellness and tobacco use adjustments outside the permissible 2 to 1 band; requiring review of changes in the benefit level rate adjustment factor.

Under controlling small group market utilization we heard the following options. Create open enrollment period for individuals. Require small employers to use wellness or smoking cessation programs, create a high risk pool for those individuals with potentially expensive costs, require that small group products include higher incentives to use primary care providers, require regular reviews of existing mandated benefits and repeal ineffective ones, institute a moratorium on mandated benefits, increase the individual mandate penalty and limit prorating of penalties.

Under the topic of eliminating anti-competitive forces we heard the following options and they will, again, be addressed in our report later this month. Prohibiting non-competitive provisions from being in contracts. Prohibit tie-in deals in provider contract negotiations. Limit the profits of insurance and pharmacy companies.

Under improving claims handling we heard about encouraging providers filing claims on paper to use administrates to file these claims electronically, requiring carriers and providers to use electronic means to process all claims materials and to use electronic medical records to store patient information.

We also heard about requiring carriers to penalize providers who do not file electronically or file inappropriate claims.

Under the topic of increasing transparency, the options we are considering include requiring reporting of complaints statistics, requiring reporting of detailed administrative expenses on supplemental financial statements, requiring a reporting of all cost containment efforts.

Under standardizing the authorization processes across HMOs, we heard about requiring carriers and providers to follow the same processes to authorize requests for service. Require carriers and providers to use the exact same medical necessity criteria.

Under standardized billing and coding processes across HMOs, we have looked at limiting the look back period for carriers to audit prior payments to providers, requiring all product benefits and cost sharing to be the same, requiring carriers to collect all co-payments, deductibles and other cost sharing.

Under the topic of standardizing HMO administrative processes, we have heard about further standardizing the credentialing process across all plans. Prohibiting carriers from transferring mental health care to carve out organizations, requiring all providers to accept global payments at sometime in the future, requiring plans to penalize employers for filing retroactive changes to enrollment.

Under the topic of reducing burdensome administrative processes, we have heard about the making the HMO licensing process a biannual process, also requiring electronic submission of HMO licensing and accreditation filing materials, eliminating the requirement to notify an insured that a referral has been approved, eliminating the requirement that HMO evidences of coverage be sent into the Division of Insurance for review, eliminating the requirement that HMO's put premium on documents to covered employees, eliminating the requirement that HMO send annual provider directories to employers, reducing rate filing requirements for closed non-group health plans, consolidate data reporting across state agencies to reduce duplicative reporting, enact legislation to ease the approval process for the termination of closed plans.

Massachusetts residents are blessed

with some of the most technologically advanced hospitals, best trained health care practitioners and top ranked health insurance carriers in the nation. This comes, however, at a cost.

This cost can especially impact small businesses. Between April of 2009 and April of 2010, the average small business health insurance rates increased by 12.4 percent.

We all know this is a complicated problem that requires all stakeholders to examine every available option. The Division looks forward to issuing our report in the coming weeks and working with you as we move forward.

And with that, we would be happy to answer any questions.

COMMISSIONER DAVID MORALES: Any questions from the attendees for Commissioner Murphy at this time?

If we don't have any questions -- oh, a question in the back -- Steve Bradley.

FROM THE AUDIENCE: Commissioner,

insurers that are facing this April 1st time frame for issuing their new premiums, what happens to those companies when, if they issue those premiums based on their existing data, and then their previous request that they have submitted to the Division of Insurance is denied or reduced and they have already written those policies and they are going to end up collecting premiums that are not equal to what they are projecting their costs to and let me follow up that, and then if that happens, are you concerned that there might be a run on the insurer where policyholders that have higher premiums will come back and demand that those premiums be immediately reconsidered and lowered potentially exacerbating the difference between costs and revenue?

Thank you.

COMMISSIONER JOSEPH MURPHY: I may defer to Kevin on part of the response.

We are in the process of reviewing those rate filings that we received on March 2nd. As you heard the Governor earlier in his comments, he recognizes that small businesses are in an economic emergency. We are in the process of reviewing those rate filings. If we do disapprove a filing, we have send guidance out to the company saying that they would need to refund that premium to those effected persons that are covered under that disapproval.

DEPUTY COMMISSIONER KEVIN BEAGAN: I would only add that we are looking at all of the rate filings extremely carefully.

We have actuaries that consistently look through the products to question all the assumptions that have been used.

We are looking at all of the filings at the same time to make sure we understand the implications of any disapproval.

We recognize that the disapproval process will take time not only for the Division to make its determination but if the Division does determine that it is going to disapprove any filing, then the company has the right to then schedule an administrative hearing and that hearing would happen at the Division of Insurance in the months that follow.

So we are trying to take everything into account to make sure we understand the implications of any disapproval.

COMMISSIONER DAVID MORALES: Thank you, Commissioner.

At this time I would like to call Len Nichols to the podium to begin his presentation.

MS. DEBORAH CHOLLET: Good morning, I am going to give a very brief introduction to Len. You see his bio in your packet.

Len Nichols is currently a Professor of Health Policy and Director of the Center, a new center -- Center for Health Policy Research and Ethics, College of Health and Human Services at George Mason University. He came to that position from the position of Research Director, I guess, of the New America Foundation and has -- was the Vice President For the Center for

Studying Health System Change, a principal research associate at the Urban Institute and the Senior Advisor for Health Policy at the Office of Management and Budget during the Clinton reform years.

Len comes with all of the nicks and bruises and deep cuts of health care reform and price control and we will let him talk about that.

Thank you.

PROFESSOR LEN NICHOLS: Well, thanks, Deborah, Commissioner Morales, and other distinguished guests -- I would like to thank you for inviting my testimony today on the urgency of finding policy solutions to our health care costs problems at the local, state and federal levels.

My name is Len Nichols. I am a health economist, a Professor of Health Policy, a Director of the Center for Health Policy Research and Ethics for George Mason University in Fairfax, Virginia which you may know that is the southern-most Commonwealth in the United States.

I am honored to offer this testimony today not least because I lived and voted in Massachusetts for 11 years when I began my career as teaching and eventually chairing the Economics Department of Wellesley College.

And my son was born at the Brigham in 1987, so I actually have a deeper connection to Massachusetts than any of you could possibly know.

And Massachusetts has always been a beacon to our nation from before it was a nation right up until and including this morning.

Our political leaders at the moment are engaged once again in a great national debate about whether to use government power to set new rules in the Senate so that our health care system can serve all of our citizens in an economically sustainable manner or not.

And, once again, all eyes are on Massachusetts. You have led the way in implementing the law and policy that has reduced the percentage of your population without health insurance to a level that the rest of the country can only envy.

And, once again, you helped fellow Americans see what is possible and in many important ways, it helped perform legislation that the Congress will finally vote on in the coming days and weeks is patterned after your own.

But just as the fate of national reform hangs in the balance, you too have much unfinished business with your policy choices as well. For the common issue that vexes Massachusetts and national, political, business, health system and thought leaders is what to do about health care costs. This issues is perhaps the primary conundrum in the national debate and, of course, you already know that if you fail to address it accurately, your own stellar coverage gains will come undone and your own middle class will find access to timely high quality of care increasingly out of reach as it is already in the rest of the country.

This is and would be a failure of leadership of a very high order.

So what is to be done?

There is, of course, no shortage of advice on this score and you will hear and read more than your personal share of the very best kind this week and afterwards.

I happen to know how smart and well informed the people are who live nearby and want to help you make the right choices for Massachusetts.

My task this morning is to set the context for why you must act while being paralyzed by a complete lack of certainty by so confusion and by partisan demagoguery is dangerous for Massachusetts and for our country.

Let me begin with what I think is the graph that conveys all other ideas. This is why we are having this conversation as a nation and it is why we must act to reduce costs.

It shows the ratio of family premium to medium family income across the country in various years.

'87 is the first bar and I picked that year because it is a year for which we happen to have very good data. In 1987 the family policy took about 7 percent of median family income, and that or course is the income that half make more and half make less.

Go out one bar and you get to 2006 and I picked 2006 for an important reason. That is the year when the candidates in 2008 for President make a go/no go decision. They have been to Iowa four times. They have seen how they look in flannel shirts and they learned to talk like farmers and they decide to run or not.

And isn't it interesting that 20 candidates both parties felt compelled to have a health care plan at this time. Why is that? It is not because they want to talk about health care reform -- trust me -- they would much rather than talk about Pakistan.

It is because the middle class is

worried about how to pay for it and the reason is right there. It is because by 2006 the family policy was 17 percent of median family income.

Now if you take the last ten years and trend out ten more years from that 2006 magic moment -- just let premium grow like it has and median income grow like it has, you will get to a choice about your religion about economics. If you believe what economists believe and that is that employer contributions have to be paid for out of productivity and do, therefore, come out of wages -- then you have to count employer contributions as part of income as I do in the first two bars.

If you believe that, then you count it and then ten years from now health premiums are only going to be 34 percent of median family.

If you believe what some of my friends in the labor movement believe and that is that it comes out of wage -- out of profits and then you don't count it as income, it comes to 45 percent.

Now truth, of course, I will tell you is somewhere in between. The truth always is. But I will tell you this too in economics we have concepts for something between 34 and 45 percent of median income -- it ain't going to happen. It is not go to happen. We cannot go there. We cannot afford that. That is the fundamental point. We cannot afford business as usual. We are not going to move to a world in which half of our population pays a third or more of their income to cover the payment, it is not going to happen. So something has to change.

This is the next reason -- oh, let me back up, sorry. These are all national data. In Massachusetts, you know, you are rich, right, you have very high incomes and it turns out you also have high premiums, it turns out you have a little bit higher income than you do premiums. So you right now in 2008 only need 16 percent of median family income to pay for a family policy.

But you are on the same trajectory as everybody else. In fact, what I learned this morning is that you are actually on a worse trajectory than everybody else so you too will get to the mid 30's by yourselves.

This is the next reason. We don't really have a choice. Now this shows Medicare -- I won't belabor Medicaid -- I assume you all know about that since you deal with that every hour, but Medicare drives home the point at the Federal level, of course, the main reason for our fiscal imbalance which is serious is Medicare cost growth and this is the simplest way to look at it -- it is shows the share of GDP that Medicare claims, 2008 3.2, ten more years 2020, 4.5 that would be a one third increase, that means to keep it as solvent and as functional as it is now that means you would have to raise taxes for Medicare by one third and keep going it gets worse as boomers retire and age and as current health care costs growth continues.

So what that says is that we have to increasingly give up larger and larger fractions of our total output at the Federal and State level just to maintain the promises we have already made.

Then you don't really have a choice. Sometimes the hardest choices are when you have no choices at all. We are going to have to address this.

Again, in Massachusetts you look like a very high spending state if you just look at unadjusted dated. The amazing thing about the team Stan assembled is that they did all the right adjustments and that gets your utilization down to pretty much average.

Well, I am here to tell you you shouldn't be proud of being average in utilization in the Medicare program. You are right there like everybody else. You should do better. In fact, if you don't do better in Massachusetts, just think what it is going to be like where people talk like I do. It is not going to go do well in

Mississippi, Arkansas, Louisiana and so forth if y'all don't lead the way. I will have a seminar on how you say y'all.

But anyhow we need you to get after this a bit more intensely -- and here is why. This is from the Congressional Budget Office and we know they do a lot down there to save paper so I apologize for the number of ideas in this one graph, but it has two reports.

One is a bar chart -- I'm sorry, the line, the line graph which is the most important number actually in this discussion of the deficit and that is the debt held by the public -- that is we owe each other -- as a fraction in GDP so it represents in some sense our indebtedness relative to our national output and you want to read that against the right hand scale and what you see is that the least recent excitement has got us up from avoid 40 percent of GDP to over 60 -- it is actually about 67 rising slightly over time if the current law continues. That is an important number. It is a big jump and I want to put it in historical context in a moment but right now I want you to take that in your head and then focus on the bar charts because the bar charts show us the fraction of GDP right against the left hand scale that we spend on interest.

Today is it is about 1 percent of GDP on interest and within ten years it will be 3 percent of GDP and rising.

Now moving from 1 percent of GDP to 3 percent of GDP does not excite many people who aren't economists. I agree with that. But let me tell you a secret -- that is big money. 2 percent of GDP more to get us exactly what in terms of services for our population -- zero.

To put this in perspective to cover the uninsured nationwide would cost one percent of GDP. So when you squander 2 percentage points more on interest, you are squandering in the easy case for covering the uninsured and that is why it is becoming so hard in Washington to have a conversation about this. So we have to get our dent down. Now let me get you in context here because there is nothing better than history to do that.

This is debt to GDP over a longer time frame and I want you to understand this. It is actually fairly rarely discussed which it is unfortunate for a nation.

I want to take you back to World War II and show you we started at 40 percent GDP, and debt held by the public went up to 110 percent -- why -- because we had to borrow to build all those battleships and B17s to go tearing around the globe. That turned out to be a good idea. We didn't really have a choice then we had to do that and, no, we did that and kept the third grade and Mass. General open. We managed to this because you borrow when you have to.

But then, and this is really important, starting in '46 we had what we had lost and we had a bipartisan consensus to pay off the debt overtime.

It is possible. We had it once. We had a bipartisan -- look it went down from 46 all of the way a little pick up around OPEC basically the rates and that is when we lost the bipartisan consensus and as an economist I will tell you you can have whatever size government you want but you have to pay for it.

If what you start doing is cutting taxes without cutting spending, then you are saying you are not willing to pay for the government you want. That is a problem.

And note the debt from GDP went from about 25 percent up to offer 47 percent while the economy was booming.

And then Clinton with a fair bit of uncooperative help from Gingrich, they sort of fashioned an involuntary bipartisan consensus but they did -- God love them both -- and they started to turn it down and so we actually remember when Clinton left office, Republicans were in the Congress and had a 200 billion dollar surplus. Where did the hell did that go?

Then what happened, of course, W1 wanted to cut taxes again. We don't have a bipartisan consensus about paying for tax cuts, our wars, our Medicare and then -- boom -- the great recession hit.

I want use the D word, I don't want to panic civilians. It was not a depression. But it was not a depression mostly because we knew about the last depression to intervene -- remember Paulson and Biernacki going up to Congress in October '78. I will never forget it interrupted playoff baseball. There I am wanting to see the 7th inning and I get Nancy Pelosi on TV.

And what you saw was a tremendous amount of fear, why -- because Biernacki, the economist, thank God was in that position and actually understood the Great Depression and spent his whole life studying -- okay, for all of your students out there -- it is a good thing to study one thing forever -- your day will come -- and at that moment he was the one guy in the right spot who could tell members of Congress we don't have a choice, sports fans, you have got to borrow and spend money because we face an existential threat to our way of life just as serious as World War II and every macroeconomist on the planet agreed we have to spend money and so we did.

Now it turns out that blip in the GDP was partly due to the Bush tax cut plan and partly due to the stimulus. The stimulus itself added about 25 percent of that surge -- that ain't the problem. We had to borrow to keep from having a depression. The problem is what happens next.

The problem is we don't have a bipartisan consensus about how to bring that debt down. That is why we are locked into ever increasing interest payments and that is why we are locked out of squeezing out the priorities we all share about how to make the country and state decent and strong at the same time.

So when I look at health reform at the national level from a fiscal perspective, it is only worth doing if it begins to reduce the deficit which according to the non-partisan Congressional Budget Office, it does.

So to argue against health reform on deficit grounds is frankly a kind of intellectual dishonesty of a rather high order. We are used to that, of course, so I couldn't belabor the point.

I will just say that the important stuff about health reform is actually not what CEO score slightly reduced the deficit. The importance is what CBO didn't score and that is the payment reform stuff at the end, all right, all of that stuff about accountable organizations, medical home, the conversation is quite similar to what I am hearing here.

In fact, of course, your work is very much being watched in Washington because you had the courage to make the first step.

We all pray you have the coverage to take the second step and then the people down there will have the courage to make the first step.

So what is the deal -- I would say you are going to hear a lot more about solutions coming forward my task was to make you sort of believe A, you can and B, you got to take serious steps and save costs overtime.

What I would say is the one issue that has not gotten nearly enough attention either analytically or frankly politically is the reality of local market power.

Now the Attorney General report is going to speak for itself and I won't step on her toes. I will just say read it, read it again, read it a third time, think about it hard. It is real.

Now the problem from the economics point of view is that when you have got real market power, you have only got three tools, antitrust, regulation and countervailing market power. I will tell you that you are going to need them all but the truth is antitrust can't help you much if what is going on is legal and lots of it is legal -- maybe all of it for all I know so you are kind of stuck if the problem is derived from a reputation that is in people's minds -- more powerful than data at least the data that I have seen so far. Maybe I should see more data -- I will leave that to you. But the point is it can't help you much in every case.

Regulation is the temptation of everybody in a hurry and Lord knows we should be in a hurry and you know, one of the reasons that I have been around as long as I have is I'm so old I am in a hurry too. This is my last shot, okay, but I am going to tell you that regulation also smacks up against all sorts of instincts that are good in the American market system and, therefore, you want to go carefully down that path and I would say avoid it if you can, therefore, you are left with what I think is the most important and useful tool, countervailing market power, i.e, buying power.

That includes the power to regulate information flows so we can get more transparency out there.

Transparency may end up being your best friend particularly with public opinion about reputation and so forth. Performance should match that or not but first you have to show what performance is.

So I would just say pay close attention to countervailing power. Three elements there -- first, just like the Federal bill does, you have got to signal business as usual is over. Business as usual has to end because we can't afford business as usual any more. We simply cannot afford it.

We just went through that class, we cannot afford that, so we have to do something different. The signal that business as usual is over is extremely important in a world that is pretty decentralized by health care costs. Because what you really need is not a bunch of smart people sitting in some room and mail out the answer, you need participation by your local providers which are different throughout this Commonwealth.

You are not going to get full speed participation and engagement in thinking about new incentive and measurements structures unless they know that the status quo is going away.

So it is a signal that leads to an engagement of behavior that you need to make in my view appropriate policy and health care choices.

And, second, a lot of people have concluded and I am certainly among them a fee for service of 10,000 CTP codes is probably not the smartest system for the 21st century. You are not going to get efficiencies if you are arguing what you paid for a particular code. It is not going to happen. You need to broaden the scope of what you pay for and broaden the accountability measurement that you are actually holding -- that you are going to pay forward.

But I will tell you and the Attorney General makes this point quite clearly just ending fee for service alone is not enough. You can still have a market power problem and have it all bundled. You have to deal with market power or you are not going to get where you want to be and, finally, and this is a lesson that I would say that came to me partly through the Center for Studying Health Systems Change and partly through Stan and Stuart Altman's group at Brandeis and partly through what I have been through in the last couple of years trying to figure out how to create space for a decent policy conversation in the District of Columbia which is a challenge.

It turns out that one of the things we need more of are progressive private sector voices. I will say something I think probably a lot of people would agree with -- no single human has enough wisdom to solve this problem and I guarantee no human in government in Washington has the wisdom to solve this problem.

But I predict that it is probably true in Massachusetts too although you do appear better than average I will assert.

So you are going to have to listen. In fact, I would says as a nation, our biggest problem right now is we don't know how do listen to each other any more. I don't know what the hell happened there but we need to learn to do that again. We need to listen to the private sector and the problem is you can't just do the easy ones and pick trade associations. Some of my best friends are in the trade associations -- let me make that clear but trade associations are all flawed. They are all too big. They all grow to get clout that is human and normal but then it ends up they have to protect their weakest members and so they end up having to suppress the progress -- the voices you need to listen to. So you need somebody else to bring you the progressive voices -- I volunteer myself and Stan and Stuart and so forth.

But any way the point is here is what they taught me. First, thing about, in fact, try to implement the concept of evidence based regulation to go along with evidence based medicine -- and by this I mean let's think about the redundancies that we have right now in all kinds of quality financial and even educational regulations. I know a very, very high quality public health system in Denver is inspected by eight different creatures every year, same check list for quality, same health and performance and the CEO has to spend eight weeks a year with different people all basically trying to find out that she is as good as her numbers look like.

We have a word for this -- it is called stupid. We need to do better than this and we can do better than this and you surely can think about similar types of redundancy that can be overcome.

Second, we are America. We are not

going to go to single payer. We are going to have multiple payers. That is one of the benefits of our system and one of the sources of inefficiency.

So if you think about sharing very good incentive information and I would say quality information across payers so we all have similar incentive structures.

Why should a hospital have 14 different pay for performance schemes -- God help us all. That may require by the way some creativity about regulation, again, why -- because you may need state anti-trust people to help up with the feds so they can all get in the room and talk. Right now you can't assemble all of the payers and providers in one community and talk about incentive structures -- it is illegal.

We also think that that is stupid economics and you have policy makers that can help you fix that and I believe you can.

Third, the private sectors folks who run real systems around the country who I consider to be progressive voices are quite clear on this point -- just tell me what the incentives are and get out of the way but reward me for doing the right thing and punish my brethren who don't.

There is no reason on earth that we should be as tolerate about subpar performance and high cost activity as we have been as a country and I predict as you have been as a state.

And, finally, on this point of no one has pure wisdom, think about making a public private partnership, the task of which is to teach best practices everywhere.

Some hospital in Worcester figures out a way to make sure we never have a central will line infection again -- that knowledge ought to be nationwide in less than a year.

Now your own Institute of Health Care Improvement in down in Berwick does a great job of pushing that and as far as I can tell about 200 hospitals out of 3,500 in the United States really are benefiting in a serious way from that flow of information.

That would be a low percentage and we can do better than that is but only if we make it clear business as usual is over and we have to move to a better world and I thank you for your time.

(Applause from the Audience.)

MS. DEBORAH CHOLLET: Do we have any questions immediately? Yes --

FROM THE AUDIENCE: Now, I am wondering what are the incentives for physicians or hospitals that develop best practices to actually propagate and disseminate that information?

PROFESSOR LEN NICHOLS: Good question.

FROM THE AUDIENCE: And the flip side, what are the dis-incentives or incentives for people with bad practice to abandon bad practice?

PROFESSOR LEN NICHOLS: Very good and it is quite symmetric -- I love the way you bracketed that question.

Let me first say the incentive of those who figure out the best way to spread is not great unless you reward them for constantly finding it.

So what you want to do is build in a system where if you get there first, you get the most savings.

So let's imagine Hospital A learns how to reduce, let's just say treatment of knee surgery with high quality outcomes and all of the stuff we always measure and they are 20 percent below the average.

Well, then you want to give them a payment that allows them to reap that gain. So there is their gain. Then you say to the other ones, look, if you can do this, you too can share in the savings and by the way here is how, all right, and over time we all can get there and meanwhile the one that is doing the 20 percent maybe gets a grant to study to do more and so forth, maybe the hip, shoulder.

So you have to constantly reward the innovators but you have got to make clear we want the whole country or the whole state to get to this 20 percent below average. We are all be going to be lead woe be gone, by God. Trust me, there is enough overuse out there in say Florida and Texas and Mississippi and you have always got those guys to compare to and hopefully the Federal government will get its act together and they will start driving the system as well.

So the first thing is you want to have incentives to innovate and reward them for high quality performance.

Right now if they got better at reducing central line infections, etc., they just give money back. There is no incentive to innovate right now.

So the flip -- what about those who are bad -- why should they gain -- well, that is the point of changing the payment mechanism.

Right now there is no incentive and frankly unfortunately right now there is no time, you guys are busy as hell, all right, and you take a primary care doc -- they have to see 30 or 35 patients a day to make a living -- they don't have time to read, they don't have time to eat lunch.

So when you think about your going to have to teach them and you are going to have to make it easy for them -- that is what this public private partnership is about is to make it such that -- but that won't work alone -- just tell them there is a better way -- unless you incentivize it -- -- unless you make it clear that they are going to gain financially.

The ideal in primary care, for example, would be to move to a world in which they could make a living seeing 20 patients a day and you talk to primary care doctors and they will all tell you a lot of those visits are not really necessary. They are redundant follows up because they have to order them in order to make a living.

So let's change the way they make a living to a more efficient structure. They make more money seeing fewer patients but we manage all 35 better and use more nurse practitioners and so forth -- so a combination of incentive and information and I would say pressure, countervailing power, we will not pay unless you do the following once we know it is the right thing to do within some reasonable span of time.

MS. DEBORAH CHOLLET: We have a question.

FROM THE AUDIENCE: Thank you for the presentation. It is so concise. And it is nice to be able to have a conversation after it.

Have you identified in all of this any -- in a safe way -- the major resistances to doing this? Is it all money? Is it power? They are veiled sometimes but any thoughts about that?

PROFESSOR LEN NICHOLS: When certainly when people say they are not talking about the money, you can often assume that the money is in the room, but I think it is also true it is more than money, it is absolutely more than money. Part of it is autonomy, it is belief that, you know, I am supposed to do it this way, that is what they were taught maybe and/or it is a way that they think they have to do it to make a living.

What is fascinating I am sure you know is this geographic variation around the country, within the state, and probably even within the city -- and you sort of how can this be -- well, when they got to where they are whether it can be Utah or some particular hospital in Massachusetts this is the way we do things and that is what they are taught.

So remember in medical school very rarely are they taught anything about how to actually set a price. So there is a whole lot of learned economics once they leave medical school and then I would just venture the observation within medical school they are not taught appropriately enough about parsimonious issues of resources. They are taught go try what you want, let's try not to kill them and we will come back and learn from this. So fundamentally if we don't teach them efficiency -- if you don't teach them efficiency when they are young and they can make a better living being inefficient when they are old -- what are they going to do?

FROM THE AUDIENCE: Education.

PROFESSOR LEN NICHOLS: So it is a combination of education, changing incentives and then give them a pathway and you can't just say, okay, I am going to pay you more for this and less for that unless you teach them to do the right thing and that is why I think the public private partnership essentially think of it like the tool used -- the tool used in this New Yorker piece on, you know, how we learn overtime, like the Agricultural Extension Service has a county agent in every county in the United States out there teaching the farmer down where I live and everywhere else, maybe you want to thick about beans because cotton ain't doing too well -- so think about it -- why not have the same kind of resource available to a doc trying to move from a 35 visit day to a 20 visit day.

I know a practice in eastern Tennessee, a guy figured out that the elderly need more time -- that is a shock -- so he ran a bunch of physicians practice -- he created a separate practice just for the elderly but he had to go through sheer hell to do it but he forced his physicians to spend 40 minutes per elderly patient -- culture shock -- they are used to is 9 or 11 even for the elderly -- 40 minutes -- apparently first they sang a song. But anyway, 40 minutes when you do this, you get a really good history and you learn what is going on, lower admissions, about 18 percent and lower EDs by 40 percent and had them all healthy but then he figured out he was basically giving money back to the Medicare program. So he created a health plan to capture the full payment and he used the surplus to incentivize the docs to do what they knew they should do in the first place. Now the docs are happy, everybody is happy except the Medicare program because it doesn't like -- but you get it -- it is both money and culture -- you have to do both -- you can't ignore either.

MS. DEBORAH CHOLLET: Let me follow up on that.

There are always two impediments to a in State C to private public partnership certainly the outliers are protected by Federal law and that is Medicare and business plans.

How do you see them playing into a public private partnership and coordinating it?

PROFESSOR LEN NICHOLS: I think we are going to hear this afternoon that the ERISA plans are tired of paying what they pay for health care.

And I think what stunned me about your trend in Massachusetts was how the ERISA plan trend is worse than the commercial plan. That may be a first in the United States. I am very impressed with it, how bad that is.

So I think, in fact, they are likely to be highly motivated and since you know quite well since you taught both of us about this, the ERISA plan is mostly self-insured so they are really with providers.

At the end of the day it is about the physician/patient encounter, everything else is commentary.

You said it -- if we don't get this right, we are not going to get anything else right. So it is really about how do you get to there.

Now as far as Medicare, what one would hope although one might not want to bet on it, but what one would hope is that the Federal government will get their act together and make Medicare a partner.

One of the most interesting things in my view about the Centers for Payment Innovation and the language of the bill as well as some language that is already there, Section 646, I think it is, communities have the right to in a sense ask for the right to be free of all of those in order to do what the community wants to do.

Let me tell you a secret -- we are not going to solve this problem at the Federal level in one felt swoop. It is going to have to be done community by community. Every kind of community is different with different kinds of hospitals, physicians and configurations but if you agree you want one set of incentive structures and you want one set of measurements that make sense and you get providers to buy in then you have a chance to go and say here is what I would like to do -- there is a concept out of the Recovery Act associated with Beacon Community, I assume they took the name from here, in any way those Beacon Communities are going to be I think multi-payer experiments in the making of efficiency and high value of care.

FROM THE AUDIENCE: I wonder if you could speak about the way prevention plays a role until terms of costs and controlling inappropriate use of health care -- both prevention in the context of a clinical visit and a broader more community based approach to venture.

PROFESSOR LEN NICHOLS: Okay, let meal talk a little bit again about Denver Health -- that is a public system that I know a lot about and I have seen it up close and then talk about the broader public.

Denver Health, and by the way two-thirds of their patients are either uninsured or Medicaid and yet they get quality scores off the map and they are two-thirds of the cost of their competitors.

So how do they do it. They have a screen on which the electronic record sits and the physician has to turn the screen literally this much so the patient and physician can look at it at the same time and that allows them to show these patients and here is the line for your blood pressure -- what happened here -- you didn't fill your prescription -- next time you don't fill -- when you can't afford it, you tell me and we will get you the drugs because what happens when you don't -- what happens is that little blue/red graph --

they have the best compliance in hypertensive control in the United States. All non-verbal, I mean all non-written -- it is all conveyed to the population that is typically considered to be a troubled population.

Take that to the bigger scale -- fundamental problem as you know quite well is prevention is a good idea -- the payoff to investment is it is not a short run payoff.

So you can't expect private actors to invest -- it has to be invested in at the public level. It has to be public.

So I would submit that no one in our business can look at obesity trends and not be truly terrified about where we are headed.

I mean, you know, in my opinion we have to make both information incentives a much stronger component. I applaud what Senator Harkins, a good card carrying liberal supported that is now an amendment -- a penalty for smoking. I hate it and you ought to be able to avoid it if you enter an approved smoking cession program but you should not be able to avoid it just by saying I don't want to do anything. I would say the same thing for obesity, the same thing for all of the other things.

You have to turbo charge the incentives but you also have to, I think, you give them a pathway, you can't just say go by skinny -- you have to say here is how to do it.

FROM THE AUDIENCE: I am Lynn Nicholas.

PROFESSOR LEN NICHOLS: Oh, yes, yes.

FROM THE AUDIENCE: And I really appreciate your comments other than the dig about the trade associations.

(Laughter from the audience.)

PROFESSOR LEN NICHOLS: I said some of the best people are in it, but any way --

FROM THE AUDIENCE: So here is my

question. Your comment about, you know, the progressives and letting them kind of lead the market trends, I think, has great value.

PROFESSOR LEN NICHOLS: Which is how we met if I recall.

FROM THE AUDIENCE: That's right. So how do you deal though with the fact that in that kind of milieu the strong will probably get stronger and the weak will probably get weaker and then there is the whole issue of consolidation or, you know, the diversity of what we have versus market leveraging and consolidation, so how do you see that issue and that trend which is a national trend which is not apparent here in Massachusetts that much -- how do you see that playing into all of this -- as something we should encourage or discourage or, you know, what is your view on that?

PROFESSOR LEN NICHOLS: Well, I will would say you have hit in many ways the nail on the head here as to the tension between these impulses and realities.

But I would just start by asking

this question -- who would we rather have run the small in efficient hospitals in Nebraska -- somebody who knows what they are doing or someone who doesn't.

So I think in fact it is okay if we have consolidation in a certain form. What you don't want is for that consolidation to lead to price advantages which are not commensurate with value delivered.

What I hear in the data although I have not seen any econometrics, so I will reserve judgment but what I hear what I have seen in the report so far is prices in Massachusetts are not correlating with anything except market leverage.

So what I think is we have to think hard about what the consequences are. To me the solution, again, is some combination of appropriate transparency, countervailing power and better payment policy which will enable folks to make the better living doing the right thing the first time as opposed to just using pricing power to cover up many sins.

You probably know and I am sure you do, roughly today according to MED PAC data three fourths of hospitals lose money on Medicare, but they almost all have positive total margins and they make it up by charging private payers a hell of lot more than they lose in Medicare.

While that sort of works, it is not good. The problem is not that Medicare underpays per se, it is that hospitals are covering up inefficiencies with market power.

So we have to think about ways to enable them to make a living in the right way -- we need to pay them -- we need to pay them better for Medicare -- most of the country -- I don't know what it is like here but I assume it is better here than in most places.

FROM THE AUDIENCE: NO.

PROFESSOR LEN NICHOLS: I am sure it is less than cost but in Colorado it is like half costs and in California, I mean, what is the point.

So they basically -- we have to pay better for the right, you know, for different payers but at the same time we have to incentivize increasing total quality improvement or we can't forward move.

So I think there is a balance there. I am not afraid of consolidation as long as it doesn't lead to undue market power.

What it should lead to is higher quality and lower cost.

MS. DEBORAH CHOLLET: I need to close the session to stay on time.

Thank you, Len.

(Applause from the Audience.)

COMMISSIONER DAVID MORALES: Thank you very much, Professor.

At this time I would like to invite John Ciccarelli, our Associate Vice Chancellor at UMass Boston to the podium where he is going to give us our instructions for lunch.

I would like to thank him publicly

for hosting this.

Thank you very much for hosting this.

ASSOCIATE VICE CHANCELLOR CICCARELLI: Okay, folks, listen closely.

You go down to the second floor and the second floor puts you on the cat walk. If you go to the left, you go to the campus center, and at the UL level, UL, there is the Atrium Cafe and you can get sandwiches, soups and other delectable items.

If you get on the cat walk and you go to the left, you can go to the Quinn Cafe which is in the Quinn Building, again, at the UL level and there is soups, beverages, etc.

We apologize but it is spring break and a longstanding renovation on the cafeteria began this weekend which will conclude at the end of the week.

You have a little walk but you can stretch your legs and there are sandwiches and things there and we look forward to seeing you back here.

(Whereupon at 12:45 p.m., the lunch recess was taken.)

C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS
Norfolk, ss.

I, Maureen Nashawaty, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that the foregoing transcript taken on Tuesday, March 16, 2010, is true and accurate to the best of my knowledge, skill and ability.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 5th day of April, 2010.

____
Maureen R. Nashawaty
Registered Professional Reporter

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Massachusetts Health Care Cost Trends
Final Report

Appendix C.5b

Health Care Cost Trends Public Hearings

Transcript for Afternoon Session
Tuesday, March 16, 2010

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THE COMMONWEALTH OF MASSACHUSETTS
DIVISION OF HEALTH CARE FINANCE AND POLICY

ANNUAL PUBLIC HEARING UNDER
M.G.L. c. 118G, SECTION 6 1/2
HEALTH CARE PROVIDER AND PAYER COSTS
AND COST TRENDS

PANEL:

David Morales, Commissioner, Department of Health Care Finance and Policy and Chair of Public Hearings

HELD AT:

University Club, 11th Floor
Joseph P. Healey Library
University of Massachusetts, Boston
100 Morrissey Boulevard
Boston, Massachusetts 02125

Tuesday, March 16, 2010 Afternoon Session
Commencing at 1:20 p.m.

COPLEY COURT REPORTING
The Mercantile Building
71 Commercial Street, Suite 700
Boston, Massachusetts 02109
(617) 423-5841

I N D E X

PROCEEDINGS

COMMISSIONER MORALES: We're going to get started with the second part of our hearing today with Attorney General Martha Coakley, so, Attorney General, whenever you're ready.

MS. COAKLEY: Good afternoon everybody, thank you, Commissioner Morales, and thank you, Commissioner Auerbach and Attorney General O'Brien and Commissioner Murphy who was here this morning, for those of you who were here a very interesting morning that we hope to continue.

In addition to our Health Care Division Chief Tom O'Brien, I just want to introduce who else is here today from the Attorney General's Office, Lois Johnson who is an Assistant Attorney General who is going to make a presentation once I make some brief remarks, and also Assistant Attorney General Karen Sung and Susan Brown are here and seated with Lois are two of our experts, Dr. John Freedman and Bela Gorman who you'll hear from in our hour.

I also want to acknowledge Kim Davoncoch, she's been an expert who has worked with us for a long time, a consultant on health care contracting who has been very helpful to us including this report and the work we have done in the Health Care Division.

We do have a report that we will distribute to any of you who want once we are done but we hope you will listen to the presentation so you can get the highlights of this as we go forward, and I just want to say first of all, it's my pleasure to be here, not only so we can make our presentation but so that I can get educated with all the great work that is going on in Massachusetts and as far south as the Commonwealth of Virginia.

So, we are presenting our results today of our office's examination of health care costs trends and cost drivers, that's pursuant to the, what you have heard a lot about today, Chapter 118G, Section 6 1/2 B.

We know that the Commonwealth led the way on access to health care and we believe that we can lead the way in keeping health care affordable. It's not going to be easy or quick, you've heard that before and you'll hear it again, and it's going to require the best thinking and efforts of all of the parties in the system, the not for profit, the for profit, government, private sector but we think that these hearings and we hope that our report can play an important role in providing the information that will give us the basis for critical policy discussions and action thereafter.

The importance of this one issue, the containing of health care costs cannot be overstated. We're fortunate to have excellent quality of health care here in Massachusetts and excellent institutions who lead us in providing for that health care.

They are the anchors of our community as we've heard, they are employers and they are our past and I believe and hope they will be the future of Massachusetts, but employers here in Massachusetts, whether they're big business, small business, they are towns or cities, know that the cost of health care is an issue that we cannot continue to afford to ignore because we cannot afford it.

We understand our progress is going to be at risk, the progress we've made so far in access if we find that health care costs get beyond the reach of our employers and particularly of our residents.

We have a unique opportunity that we're going to try and highlight and this is the equivalent of a pocket call, putting up the conclusions here, so, these aren't related to my comments at the moment, but the report that we're going to highlight today has, I think gives us a unique opportunity to address the information that we uncovered through enormous amounts of work by folks in our office and with help of some of you in this room to provide a mirror of and a transparency into a health care system.

We think that this information is unique not just in Massachusetts but in the country. The legislature has authorized us to do it and these hearings I think are important because we must diagnose what we need to correct.

We've taken our charge to the Attorney General's Office seriously and we hope that this health care report will identify in the health care market an informational baseline as we strive to control costs while maintaining access and quality.

So, what did we set out to do in doing this report. We wanted to look at cost drivers in Massachusetts market and we first wanted to understand how prices are established for health care services.

At the outset of the review over a year ago we were aware that the providers of health care services were paid different prices by insurers. What we did not understand well enough before we started is how parties arrived at those prices and what was the basis for disparate prices paid for the same type of services.

First, the prices paid to providers are the result of dozens even hundreds of discrete negotiations. Each insurer negotiates with each provider or provider network whether a large academic hospital, whether it's a small community hospital, a large physicians group or a small practice and establishes a price paid for health services.

The price typically for a particular service, what we refer to as a unit price, but may also be a capitated rate that is a price paid to cover cost per patient.

Second, far more challenging than establishing just what the price is paid was to learn what drove those negotiations and what ultimately explained the variations in prices paid.

The analysis was both qualitative and quantitative and we spoke to parties who negotiated the contracts and we analyzed the data that might help explain those disparate prices.

We considered conventional wisdom on why health care prices might vary so materially, for instance, whether it was difference in quality, difference in the health of the patient population, whether the provider served a large Medicaid population which to some degree is subsidized with private payments and whether it was related to the costs of an academic medical center.

We sought to evaluate the explanations for disparate prices. Are the price differences explained by high quality of care or the complexity of service or the sickness of patients, and as we will discuss very shortly we did not find a correlation between different prices and many of the things that we would expect like better quality or sicker patients or teaching hospital status.

What we did find is that market leverage, the size of the organization, the various strengths that it brings to those negotiations with payers was the correlation to the price paid and the conclusions from these findings should not be in any way blaming of a particular player in the health care system.

The more appropriate inquiry is what do we do with this information now as we go forward, what do we want to do about it and what can we do about it and if we think that higher costs should be explained for good reasons like better quality, how can we make that type of incentive part of the system, some of the same questions that Len Nichols just asked very well before lunch.

If we think that high quality community providers should not be at constant risk because they may not match the negotiating levels of the largest providers, how can the system reflect that desire, and I am committed as I know my office is, as I know many of you here in this room are here today, including the Governor, the Senate President, the house and the legislators who spoke here this morning, we are committed to working with the doctors, the hospitals, insurers, the business community and all the other stake holders to make sure that we get the right solutions as quickly and practicable.

Before we move to a presentation on our review and findings, I want to note that our report does reflect a massive amount of information we received from providers, all of whom were incredibly cooperative with us and provided the requested information and individuals with whom we spoke.

That cooperation was essential to fulfilling our mission to date and I believe that cooperation will be there as we move forward to seek some solutions to cost containment.

We will as I said at the close of our presentation provide copies of the hearing, it's also going to be on our web site, and I would just note that if we have time, I know Commissioner

Morales has been very effective at keeping us to time, I appreciate that, if we have time we would be happy to answer questions, so, I would ask for efficiency if you have questions, write them out, we'll collect them and if we cannot get to them, we'll make every effort to respond to you, so, if you want to put your name and your own web site or E-mail we'll try to respond to you after the hearing.

I'm going to turn now the hearing over to Assistant Attorney General Lois Johnson from our Health Care Division. She's going to highlight some of the key findings and she will be followed by the experts with whom we worked to make sure that our perspective and our work was as accurate as possible, and so let me get off of this web site so I'll let you get to where you want to be.

MS. JOHNSON: As the Attorney General said, the results of our examination are detailed in our written report which will be available today both on our website as well as we expect the Division of Health Care Finance and Policy website and several copies will be available after our presentation, but today I'm going to walk through some slides that illustrate six of our seven key findings.

Those findings that I'll talk about are No. 1, like the Division's own analysis -- I'm missing one flag here, I'm not sure why, No. 1, like the Division found there are wide price disparities across the Commonwealth in physician rates as well as hospital rates, No. 2, that those disparities are not explained by, as the Attorney General said, expected value based factors like quality or complexity, that 3, those disparate pricings are explained by relative market leverage.

No. 4, we found that payment methodology does not correlate with variation and total medical expenses, 5, now we're on the right slide, those price increases, that price is a significant cost driver of overall medical trend, and finally, that 6, those higher priced providers are in fact gaining market share at the expense of lower priced providers.

The seventh finding regarding contracting practices and provisions that reinforce and perpetuate those market disparities are described in detail in our report. Two of our experts will follow with more detail on how we approached the role of analyzing quality and price to arrive at these findings, and as I said, these slides are taken from our report in more detail and more slides are found there.

So, first, our analysis showed that payment rates for physicians and hospitals vary significantly across the state and the results aren't the same for each major carrier that we looked at, so, it's not just with one particular health plan.

This slide, for example, is a graphic representation of the waterfall of comparative payment rates among physician groups across the state. For example, here it shows that there is a 90 percent differential from the lowest paid physician group to the left to the highest paid group to the right and that variation is the same on the hospital side.

This next slide shows a similar waterfall this time showing the variation in prices paid by one particular insurer to hospitals in Massachusetts and here we see a hundred percent differential from the lowest paid hospital to the left to the second highest paid hospital, and you can see there's a significant variation from the second to highest paid but from the lowest to the second highest it's a hundred percent differential.

So, what accounts for that variation in payment to these providers who offer similar services and often offer those services within the same geographic area.

We looked, as the Attorney General said, at a variety of factors, those factors most often associated and cited to explain with differences in rates to see if we can explain these differentials.

For example, we looked at whether those higher payment rates are tied to a proportion of government patients that a hospital serves and we found that they are not tied.

In this chart you'll see that the hospitals with the higher mix of government versus commercial patients known as disproportionate share hospitals or to many in this room dish hospitals, those hospitals are identified in red.

This chart shows that the dish hospitals are not among the highest paid hospitals, they would be clustered toward the right of the graph, but instead tend to be among the lower paid hospitals across the state.

In fact, our data shows that overall commercial payments to dish hospitals are roughly 9 to 25 percent lower than commercial payments to non dish hospitals. So, variation of rates is not correlated to the high proportion of government insured patients.

And a note here about quality, our expert, Dr. John Freedman, will detail for you the quality metrics we used and compare to price and payment to arrive at our findings that there is no correlation between prices paid and quality.

So, two other factors that we looked at, teaching status and complexity of services. So, one might assume and many have assumed that teaching hospitals are more expensive than community hospitals, that they get higher prices, but we found that this is not always the case.

On this slide teaching hospitals are identified in red. If all teaching hospitals were among the highest paid hospitals in the state, they would be clustered to the right side of the graph. Again, here they're not. In fact, for this particular health plan whose data you see on the slide, of the top ten paid hospitals only two are teaching hospitals.

So, another factor represented here is sickness or complexity. We found that the relative sickness or complexity of the patients cared for by those hospitals or even on the physician side, the health status of patients for various physician groups do not correlate with payment rates.

So, the yellow tape on this graph shows case mix index or CMI for each hospital across the state. The CMI which is calculated by the Division of Health Care Finance and Policy shows the relative complexity for patients treated at a given hospital. A CMI of 1 is an average score, hospitals with a higher CMI serve a more complex or sicker population on average.

Of the top ten hospitals for this particular payer, only two have CMI's above average, so, we've seen that complexity doesn't explain higher rates and we've done the same analysis on the physician side and found no correlation between higher rates of payment and health status of the population treated.

So, we found that for the value based factors as we're calling them of complexity, quality, academic or dish status, there's no correlation, no positive correlation with the price.

We also found, and this is detailed in our report and actually Bela Gorman will discuss this in her remarks, that those high rates of payment are not adequately explained by hospital unit costs, the cost to the hospital performing the services, so, where did we see a correlation, what does explain the significant rate of disparities that we see in the marketplace.

Well, one factor we found, one significant factor is market leverage. Now, both insurers and providers bring leverage into the negotiations to result in payment rates.

Providers can have leverage based on their size, their dominance in the insurer's network, their geographic location, whether they offer specialty services, whether they have a brand name. So, we looked at market leverage in a few different ways and one way was to focus on that provider size.

Looking there, there are two measures of size, one is revenue, the number of health plan dollars going to a particular provider and second, members or membership, the number of health plan members associated with a provider or provider system. So, using those metrics we found that payment rates do in fact correlate with market leverage.

This graph shows the comparative market leverage among our major adult academic medical centers, so, on this graph we illustrate the relationship between the price the hospital gets paid with higher prices going toward the right and your size, here shown by revenue, with a greater revenue going up to the top and the size of the bubble, another factor, represents another aspect of size, the members, the number of health plan members associated with that particular hospital.

So, you can see in this graph that the hospitals with the higher market leverage, they're bigger and up higher on the graph are also plotted furthest to the right on the graph because they're also the most well paid.

So, it's important to note as Dr. Freedman will discuss that quality does not distinguish these providers but their respective market leverage does.

And as we heard over and over in our interviews with health plan players, provider size whether looked at in terms of revenue or membership is a significant factor in their rate negotiations and there are of course other important factors that contribute to market leverage both on the provider side and the insurer side and we discuss those in our report but this slide shows the market leverage due to size.

Next we looked at another financial metric that is useful to comparing providers. Total Medical Expenses or TME tracks the per member per month costs of delivery and care associated with a particular physician group.

TME captures all costs, all spending and accounts for both the price of the services and the volume of services used, and our expert Bela

Gorman will describe it in more detail about the metric of TME and its value, but when we compared the TME of physician groups we found that the TME does not correlate with payment methodology, that is whether that physician group was paid on a fee for service basis, here represented by the blue bars, or a risk based basis, capitated or global payment of some form, those are represented by the red bars.

So, if there were a positive correlation that one might expect with risk based payment type arrangements you would see, you would expect that the red identified physician groups would have lower TME clustered towards the left of the graph, but as this graph shows there is no correlation.

We see that some of the risk sharing provider groups have among the highest total medical expenses in the state. We showed that the method of payment or how physicians get paid does not predict whether or not they'll have lower or higher medical expenses overall.

Next using the data that we gathered on medical trend we can see the overall impact on price and many have talked about the role of price today and we want to highlight its importance.

The data from three large health plans that we looked at show that the increasing prices paid for services and not the increasing use of services has been primarily responsible for the increasing health care costs overall over the last few years.

For example, this slide shows a breakdown of the various factors that contributed to cost growth from 2004 to 2008 for this particular insurer and that's what we mean by medical trend, those factors that contribute to cost overall.

Here you can see in blue that on average over this period, 50 percent of the cost growth is caused purely by price increases. An additional 20 percent we're told of this insurer's cost growth is attributed to location or provider mix, patients getting care in more expensive providers and that factor is captured in the purple band.

The remaining 20, 25 percent of trend is due to a combination of utilization and intensity, the substitution of more intense services. So, while utilization is important, it's a component we found and I think is echoed in the Division's findings that price is a far more significant cost driver in Massachusetts, and Bela Gorman will give some more details on medical trend analysis and the role of price.

Finally, we looked further into the trend of where patients are getting their services, the provider mix and the effective price in disparities.

As the last graph showed the change and location of services from lower cost to more expensive providers can have a significant impact in overall cost growth. When we reviewed this chart data, we found that lower cost hospitals are losing volume to their high cost competitors even when they offer comparable quality as we have shown.

Our analysis shows and is represented on this chart that hospitals who are paid above average prices gained 2.88 percent in inpatient volume over the past three years while hospitals paid below average prices lost 1.15 percent in inpatient volume during that same period, so, we're seeing a shift.

The shift in market share from low cost

to expensive providers represents an overall cost to the system, in the short term, the same health care services are costing more, and in the long term if the pricing trends we see continue, lower paid providers will continue to lose volume and be forced to close or we talked about mergers with larger systems further exacerbating the overall cost trends.

Before I turn the presentation over to our experts, I just want to a say few words about our examination. As the Attorney General said, our review was extensive and thorough over the course of a year plus we reviewed thousands of documents.

Our team, especially Assistant Attorney Generals Susan Brown and Karen Sung, reviewed contracts, quality and price information, we also used our unique statutory authority that the legislature gave us in this examination to issue CID's to fifteen providers, a range of community providers, academic medical centers, dish hospitals, physician organizations as well as to the five major players in the state, but we didn't just rely on documents, we also conducted dozens and dozens of interviews with the market participants and we asked them to help us verify our data, to verify our analytical approach as well as to verify our findings, and I just want to say that our work wouldn't have been possible without the cooperation of both the payers and providers that we worked with, and on behalf of our office and our team I just want to thank all of those who assisted in pulling this information together.

We're very pleased already that the process has resulted in greater transparency and disclosure of this important price and quality information, and with that especially thanks goes to our team of experts, two of whom will address you today.

First, we have Dr. John Freedman who is going to talk about the role of quality. Dr. John Freedman is a physician, holds an MBA, he's an expert in health care quality measurement who has done extensive work with both providers, payers and also governments.

DR. FREEDMAN: Thank you, Lois, and good afternoon everyone. My name is John

Freedman, I provided expert consultation to the Attorney General's Office in health care quality measurement through the course of this examination.

I'm a physician, board certified in internal medicine and I've also earned an MBA. My first formal position in quality measurement and improvement was at Kaiser Permanente beginning in 1993.

Since then I've worked in a variety of settings and I'm currently principal of Freedman Health Care LLC, a firm that consults to providers, payers, government entities and others on issues of health care performance, performance measurement and performance improvement.

We are fortunate that Massachusetts boasts strong performance by many measures of health care quality. For example, the National Committee on Quality Assurance, NCQA, currently ranks four Massachusetts commercial health plans amongst the top twelve in the United States. The 2009 Commonwealth Fund report ranked health care in Massachusetts as seven best in the country.

We're justifiably proud of the care

that's available here in Massachusetts, yet, we also know that health care here is not better than the national average on some measures and that variation exists on some important aspects within the state.

The Attorney General's examination did not evaluate individual provider performance or identify providers who performed better or worse than others, rather, the Attorney General's Office, which I will refer to as the AGO, examined the role of quality in the current health care system and in particular how commercial health plans define and measure quality of care and how they use quality information as they contract with providers.

Through this examination the AGO obtained extensive information on how Massachusetts health plans rate the quality of providers. The AGO examined to what extent the rate of quality of a provider determined the level of pavements, in other words, do health plans pay providers on the basis of quality. The short answer to that question is no.

I will briefly present the highlights of the AGO's findings on quality, the validity of the AGO's approach and the conclusions that I draw from them. The AGO obtained and reviewed numerous quality metrics that assessed the performance of hospitals and physician groups, including dozens of measures applied to physician groups and hospitals over several years.

Some applied to nearly all providers, some applied to subsets, such as hospitals performing cardiac procedures or to over twenty of the largest medical groups. By using the civil investigative demands, the AGO obtained and reviewed hospital and physician group information, data and reports from the three largest health plans in Massachusetts and from a cross-section of provider organizations.

As part of the examination the AGO also considered publicly available quality information on hospital and physician groups. The information produced by health plans shows that different health plans use somewhat different quality measures and aggregate quality measure information in different ways.

While each health plan takes a unique

approach to evaluate provider quality, the major plans generally select quality measures from government and nonprofit organizations that are widely used and accepted including the Center for Medicare and Medicaid Services, CMS's, process of care and patient experience measures, the Agency for Health Care Research and Quality, AHRQ's measures, NCQA's Health Care Effectiveness Data and Information Set, HEDIS, and Massachusetts Health Quality Partners, MHQP patient experience measures as well as the Leapfrog Group Survey.

In examining the measures and methods used by health plans or providers, the AGO did not attempt to reach any conclusions regarding the accuracy, statistical significance or appropriateness of those measures and methods, rather, the AGO considered the quality measures that health plans track and report to examine whether and how those measures influence contract negotiations and to determine whether those measures correlate positively to the prices paid to health care provider, in other words, are health plans paying more to providers who provide higher quality care as measured by the health plans themselves.

The AGO's review of quality information was qualitatively and quantitatively valid. Through its review of both publicly available information and privately held information produced in response to CID's, the AGO examination was comprehensive in scope and appropriately focused on the quality information and measures that health plans and health providers themselves are tracking.

Those measures are widely used and accepted within the industry. Based on my review of that extensive data collected by the AGO for the period from 2004 to 2008 have several opinions.

First, health plans and providers pay attention to and generally care about providing quality care and improving quality performance. Next, the major plans generally select quality measures from government and nonprofit organizations that are widely used and accepted.

Despite some important variation, Massachusetts hospitals and physician groups perform well across most measures and are largely clustered in a narrow to moderate range of variability between them. For example, HEDIS performance for twenty-six large groups was clustered between a performance rate of 70 percent to 80 percent from worst to best.

Put another way, the best HEDIS performer was just 4 percent better than the average of the groups. The patient experience scores were also tightly clustered near the top end of the performance range.

For cardiac procedures the state's average mortality has fallen steadily and all hospitals performing these procedures are clustered closely together.

Last, the evidence shows that no provider is consistently a top or bottom performer across measures. There appear to be fewer measure differences in quality from provider to provider than would be suggested by popular opinion or perception.

Comparing price to quality, with this information collected the AGO examined whether the significant pricing disparities it had found in each major carrier's network could be explained by differences in quality. To do this the AGO compared the health plan quality data I just described to price data using dozens of graphs and comparisons to determine whether there was a correlation between price paid and quality measured.

These graphs include comparison of physician and hospital prices and payments, excuse me, prices and payments to the insurers own quality and mortality scores for these providers as well as the publicly available CMS process and agent's hearing scores.

The AGO looked to see if what the market players themselves use as measures of quality drove their business in important ways such as negotiating payments. For example, when a health plan chooses a particular measure of quality to valuing its provider network, the AGO examined whether those same measures were correlated with that plan's payments to providers.

If the market were indeed organized to reward quality, we would expect to find a positive association between a payer's quality rating for a provider and the payment rate that the payer negotiates with that provider.

The AGO's analysis shows that the wide variations in price we documented are not explained by differences in quality of care. The AGO found no correlation between price and quality and certainly not the positive correlation between price and quality we would hope to see in a value based health care market.

For example, the AGO examined the relationship over three years between Blue Cross and Blue Shield's payment rates and each hospital's performance on the AHRQ measures which Blue Cross Blue Shield uses to evaluate hospital performance.

For that period of time the AGO found no positive correlation between hospital performance on AHRQ measures and their rate of payment. There were many examples of higher performing hospitals being paid less than lower performing ones.

There was no evidence that Blue Cross Blue Shield paid hospitals based on how they performed under the quality measures that Blue Cross Blue Shield used to track hospital performance.

Similar results were found with Harvard Pilgrim and Tufts Health Plan data. Based on the data provided by these health plans, the AGO found that hospital payment disparities are clearly unrelated to the quality of care as measured by the plans and by CMS.

The examination showed the same results on the physician side, for example, Tufts Health Plan physician group data clearly showed no relationship between quality and payment as well.

For Blue Cross Blue Shield there was a moderate correlation between price and the HEDIS measures used to assess physician groups and that was the only example we found in the many comparisons where there was at least some correlation, but there was no correlation for Blue Cross between its price and the results on patient experience data either for children or for adults.

To summarize, for both hospitals and physicians the AGO found no correlation between payments by health plans and the measured quality of care. In addition to thoroughly considering quality information and data, the AGO also examined senior physicians and quality experts from the health plans and health providers who concurred that there is no material difference in measurable quality in Massachusetts hospitals or physicians that would explain the price differences in the market.

Conclusions, overall the quality of Massachusetts providers is generally good. Consumers should feel confident that the Commonwealth offers many quality providers, hospitals and physician groups all across the state.

The differences in prices paid by the major Massachusetts health plans were not justified by demonstrable differences in quality. The evidence points frankly to an inconsistency in the market.

That is despite the apparent broad acceptance that quality is critically important and should drive the behavior of payers and providers, in reality quality measurement plays almost no role in the prices paid in the Massachusetts health care marketplace.

I believe we must move towards a more value based market where the quality delivered to patients becomes a key driver of payment rates. To get there the market be would benefit from 1, movement to uniform standards for measuring quality, 2, much more extensive public reporting of quality and cost information, and 3, provider contracts paying for quality to a degree far beyond current practice.

Thank you very much for the opportunity to present these findings, I hope to be able to take some questions afterwards.

MS. JOHNSON: Now Bela Gorman, an actuary and principal of Gorman Actuarial will present. She's a fellow of the Society of Actuaries and an experienced consultant to government and the insurance industry.

MS. GORMAN: Thank you, Lois. Good afternoon, my name is Bela Gorman and I'm a fellow of the Society of Actuaries and a member of the American Academy of Actuaries, and as Lois has stated I've been a principal of Gorman Actuarial over the past five years.

I have been assisting state governments with analyzing the impact of health care reform policies to the insured market. I've also assisted various carriers in pricing and financial forecasting.

Prior to that from 1999 to 2004 I was the director of actuarial services at Harvard Pilgrim Health Care responsible for pricing and financial forecasting and I've held other actuarial and underwriting positions with various insurance carriers in Massachusetts.

I'm pleased to testify today about my work on the AGO examination of health care cost trends and cost drivers. As you've heard this afternoon, the AGO found that the price increases paid by health plans have a significant impact on overall health cost trend.

I will focus my remarks today on the role of price as a cost driver and will discuss the financial measures the AGO used to analyze the health care market and the importance of accurate standard measures to track health care costs.

As part of this examination the AGO reviewed four financial measures, pricing payment relativity, total medical expense which I will call TME, hospital unit cost and medical claims trends.

So, the first financial measure I will discuss is price and payment relativity. By using civil investigative demands the AGO obtained detailed information from the major health insurance carriers on relative pricing for the Massachusetts hospitals and affiliated physician organizations in each plan's network.

The AGO reviewed relative pricing at the aggregate rather than at the specific procedure level. In other words, the AGO compared relative pricing for all services a hospital would provide rather than just one service.

I believe this approach more accurately reflects the way health plans and providers negotiate set price and resulted in valid comparisons among providers.

The AGO obtained relative pricing information in two different measures, price relativities and payment relativities. These different methods are both valid approaches in comparing relative prices by health plans to hospitals and physician groups and are well accepted measures regularly used in the industry.

I do caution, however, that because the

relativities are carrier specific and use different methods, the data should not be used to compare a cross carrier or to determine whether one health plan pays a provider more or less than another health plan.

That said, the relativities of cross carriers are directionally consistent and we witnessed why price variations in each carrier's network.

The next financial measure analyzed was total medical expense or TME which is a measure for physician groups. In simple terms TME is the medical cost or spent per patient. Each health plan calculates TME by summing annual member medical expenses for physician organizations and dividing it by total members present each month in that year. Members are assigned to a physician organization through their primary care physician.

TME includes all of the medical expenses associated with a member regardless of where services are rendered including physician visits, hospital services, pharmacy, lab, behavioral health and other services. TME reflects the volume of services used by each member utilization and the price paid for each service unit price.

The TME produced to the AGO by health plans was health status adjusted to account for the demographics and health status of the population cared for by each provider system.

This enabled comparison of relative spending per patient and insured that systems caring for sicker populations will not inaccurately appear as higher spending systems.

Since TME is health status adjusted and includes all medical services it is a great measure of efficiency. A lower TME will reflect lower utilization and/or lower prices.

TME is the only financial measure that reports on all services provided to a member and boils it down to one number that can be compared across physician groups. Through the AGO's examination it was discovered that the health carriers review this information but not routinely given to providers so they can monitor their own performance.

The AGO also received information that some health plans and physician groups review MLR as a measure of efficiency. MLR, or medical loss ratio, is the ratio of total medical expense to premium per member per month. In my opinion MLR is not a true measure of efficiency because it is not appropriate to compare physician group spending to a premium where the premium is not within the control of the physician group.

TME is a well accepted measure of cost and efficiency that is regularly used in the industry and I believe that public disclosure of health care adjusted TME would help providers and health plans to compare and address differences in relative efficiency.

However, there are some issues to be addressed. First, TME is more accurate for larger populations where the average TME is less susceptible to random increases or decreases that could result in a small population.

Changes would need to be developed to address this year to year volatility for TME for smaller physician groups such as adjusting the TME for large loss claims much like what we do for small employer groups when setting premiums.

Second, TME is difficult to track for products that do not have a primary care physician requirement. One option is to explore the possibility of developing attribution methods so that we can track TME for non HMO products.

The AGO also reviewed hospital units cost. Using publicly available data from the Division of Health Care Finance and Policy, the AGO calculated costs per case mix adjusted admissions for each hospital in the state. This is a widely accepted metric in the industry.

The AGO found variation in unit cost across hospitals. There is limited information available on hospital costs. Many hospitals do not even have cost accounting systems.

Moreover, the 403 data that DHCFP gathers each year is not used meaningfully by the hospitals. I believe that better analysis can be performed if standard hospital unit cost information were measured and publicly reported.

In order to understand cost growth the AGO examined the underlying factors that contribute to overall increases in health costs by reviewing medical trend data. All three health plans provided medical trend data and the AGO considered and relied on the industry analyses.

Trend analysis is a key function for any pricing actuary and it is routinely performed to ensure that premiums are set appropriately. The major components of medical trend are utilization, unit price, mix of services and provider mix.

The unit price component is the trend in the pure price of a service. Utilization is the trend in the number of services being provided, for example, if more office visits are being provided this would be a utilization trend.

Utilization trend will reflect the aging of a population and change in the health status of a population. Mix of services is a component of trend where the intensity of services being provided is increasing, and finally, provider mix represents a shift of services from lower cost settings to higher cost settings.

Health plans track and report the components of trends differently. While there are some differences, data from the three largest health plans show that unit price increases are a major contributor of increases in medical trends in the Massachusetts health marketplace over the last few years.

For some health plans the information produced shows that price contributes as much as 70 to 90 percent to medical trends for those plans over the past few years.

Another plan shows price contributing over 50 percent to medical trend while change in provider mix contributes approximately 20 percent to overall cost growth.

I believe that these findings are consistent with the conclusion in its preliminary report that price increases were the major driver of growth in spending for most health care services.

In my opinion, price is a significant driver of cost trend and needs to be addressed in any policy solution designed to contain health care cost growth. Efforts to address utilization are important but unless price trends are mitigated, cost containment efforts will not have meaningful impact on overall trends.

The AGO also reviewed hospital discharge data for adults from 2005 through 2008 and found that more expensive providers are gaining volume while less expensive providers are losing volume.

This is the provider mix component of trend. As hospitals with higher prices attract more patients, overall health care costs go up because patients are receiving the same service at a higher price.

It is my opinion that as market share or footprints increased for more expensive providers, cost to the health care system increased overall. This impacted medical trend and premium.

In closing, I would like to highlight the importance of accurate and reliable data to compare and track health care costs and delivery. The AGO received a wealth of information from the major health plans in the state.

I know it was a huge undertaking to pull all this information together. I commend the health plans for providing this information. I think we can use the price and payment data and other information to develop appropriate cost containment solutions.

The AGO's analysis was valid and reasonably relied on the financial information produced by health plans and health providers. Based on the AGO's analysis and my own experience, I believe that the system now maintains accurate and reliable information on price, payment and total medical expenses that should be considered to compare cost and delivery system efficiency.

Based on the AGO's analysis and my own experience I believe that the public reporting of hospital unit cost information should be improved and standardized to allow better comparison of hospital cost information. Thank you.

MS. COAKLEY: Thank you, Lois and Dr. Freedman and Bela for that information. We do have reports, I know it's a lot of dense information and I know it was hard to see some of those small names up there, but it's all in the report that will be available either copies here or on our web site. Very quickly in conclusion we have a couple of questions, and David, give me the elbow to sit down.

MR. MORALES: Yes.

MS. COAKLEY: We believe that these findings are crucial as a starting point at this stage to start to talk about where we go next in terms of cost containment solutions but we believe that we can develop those solutions.

I think there is excellent news in these reports on quality and the quality of health care in Massachusetts. I think that it is a positive launching point.

As I said earlier, to go forward noting that we provided for access, we have quality, we just need to figure out the cost of these and it is, this information is critical to include in the marketplace.

I think that we found that metrics like using the total medical expenses can be used to track provider efficiency which is going to be one of the things we need to look at and that further uniform quality metrics will help employers and consumers to choose benefit designs and providers in a way that they haven't had that option before, it's an important step forward.

I want to make it clear that this report does not point to a single or simple solutions. Indeed, we're not really focusing on solutions in this report yet.

We think that again, this is not going to be easy to do but we believe that we have some policy recommendations going forward that I think can help us provide some solutions.

Based upon our review and analysis the following recommendations we think will promote the goals of I think everybody in this room and everybody in this Commonwealth wants to achieve, that we encourage a transparency of price and quality information and provide for future standardization of price and quality measurements to give consumers, both the individual consumers and employers who are purchasing this in ways to start to measure what they're buying.

We need to mitigate market disfunction and promote prices that will better correlate to value such as higher quality of more complex services required. We want to promote prudent purchasing through insurance product design, decision making tools and education of consumers, and finally, we want to work to reform contracting practices that reinforce and perpetuate some of the disparities that we've outlined in the current market and create the market disfunction.

For example, and this is explained further in the report, parity provisions, supplemental payments, restricting provider participation clauses and unfair use of growth caps, all of which we believe do not enhance either a transparent market or the ability of the consumer to make good decisions.

As I said earlier, we look forward to working with you, Commissioner Morales, with the legislature, with the Patrick administration, with our health care providers, hospitals, businesses, municipalities, consumers in making sure that we move forward in cost containment and continue to provide for access and quality.

I do have two quick questions here, one is not so quick a question but has a quick answer for me, Len, in order to create countervailing market power, Len Nichols suggested payers collaborate in a variety of ways including sharing payment information and incentives.

He said this would require both creative state antitrust people, unquote. Would your office be willing to work with health plans to identify areas where collaboration rather than competition would be more effective in controlling medical costs and then structuring ways to encourage them to allow that collaboration.

The short answer of course is yes, so, that's the shortest answer you'll ever get from me probably, but I will say that these issues around antitrust and collaboration have come up as we worked with Dr. Bigby and we will continue to put our efforts into that because we think it is an important place to go, so, I appreciate that question.

The second question is what legal tools does the AG have to correct this problem outlined in our presentation. The short answer is I'm not going to answer that now, so, that's a quick answer, but part of what we wanted to do as we've gone through this is take this in the logical steps which is make sure that we have this information right as when we issued our preliminary report, and with this report we welcome criticism of it or concerns or issues that you may have with it.

If we agree going forward that it is the proper at least outline for the slides that we looked at, that it's correct and accurate in that respect, then we will now refer back to this question, look at what tools we have in our arsenal but some may have to come from the legislature and some may require regulation, but I think our first step is to make sure we have this right and see what goals we have going forward and what we can accomplish with everybody at the table and we are committed to making that happen.

So, unless there are any other questions, we have probably one or two more minutes. Seeing none, I want to thank our panel again for the enormous amount of work that our office did and for our experts and thank you.

(The audience applauded.)

MR. MORALES: Thank you, Attorney General Coakley. A very, very, very helpful and useful presentation. At this time I'd like to call to the podium and to the panel Wayne Burton, the president of North Shore Community College will who will moderate the employer panel.

I'd also like to call to the head table Michael Widmer from the Mass. Taxpayers Foundation, Delia Vetter from EMC Corporation, Frank Romano, Essex Management Group, Peter Mongeau, I'm probably getting that wrong, Peter, from Hancock Financial Services, Eric Michelson of

Michelson's Shoes, and Alan MacDonald from the Business Roundtable.

I look forward to a robust discussion now, not only to hear from the employers about what they're experiencing relative to health care costs but also some of the issues that and initiatives they have undertaken to address some of those health care cost increases, so, Wayne, thank you.

MR. BURTON: Thank you, Commissioner Morales, it's a pleasure to be here. I am Wayne Burton, I am the chair of the North Shore Chamber the past two years.

The North Shore Chamber is the third largest in the state with over 1,600 members, and I can tell you to set the stage that all 1,600 told me last year that the cost of health care is the most significant inhibitor in business recovery and expansion that they face.

I also want to thank Governor Patrick for meeting with the heads of all the chambers frequently on this issue, Representative Stanley, the Chairman of the Committee for her interest, and every night I kneel beside my bed and say I have 700 employees employed by GIC which pays $12,000, half of what small business pay for their insurance.

I will ask the panel to speak clearly for our stenographer today, she is taking verbatim testimony. What we're going to do is after presentations, I'm going to ask some questions of the panel, we'll take some questions from the audience but they're going to be in writing to the staff.

With that, it's my pleasure to introduce Peter Mongeau, vice president HR Shared Services John Hancock Financial Services, Peter.

MR. MONGEAU: Thank you, my name is Peter Mongeau, I'm vice president of human resources for John Hancock Financial Services and I'm responsible for our employee compensation and benefit programs.

John Hancock is a financial services company with approximately 5,500 employees nationally and 4,000 employees in Massachusetts. Our projected 2010 medical plans spent for our current employees including employee cost sharing is approximately 47 million dollars of which more than 70 percent or roughly 33 million dollars is spent in Massachusetts.

We manage another 50 million dollars for retiring medical benefits. Our medical plan increases on a weighted average basis have been in the roughly 6 percent range for the past two years.

On a relative basis, this is better than certain benchmarks; however, this rate of increase is greater than most of our other operating costs making it not acceptable in the long term to our policyholders or shareholders.

We attribute our results to two overarching strategies, one, collaboration and partnership with our health plans to invest in and improve workforce health and productivity.

Two, treatment and engagement of our employees as consumers where choice and buyer information or transparency is important given the diversity of our workforce. I'd like to share with you an example of each strategy.

We have had what is referred to as a sole source partnership with Harvard Pilgrim Health Care for the past seven years. Our approach is that John Hancock and Harvard Pilgrim team up to pilot health and productivity initiatives and to capitalize on those that produce results that then John Hancock continues to leverage and Harvard Pilgrim has the option to integrate into an overall product offering.

One successful pilot and continued investment we make is in our healthy insurance program, which is a cardiovascular risk reduction assessment and counseling service. Healthy returns has garnered medical savings of $110 per participating member per year.

These results have come from high expectations and high performance on the part of both John Hancock and Harvard Pilgrim and most notably not through hammering away at rate increases during annual renewals.

Collaboration by health care stakeholders works and helps to get at drivers of health care costs. With respect to seeing our employees as consumers, this helps to ensure we offer meaningful choices in levels of coverage where employees own and quite frankly pay for their decisions.

For example, if employees choose nongeneric prescription drugs, they pay 20 percent coinsurance of the drug's price versus a copayment which caps their expenses. John Hancock was willing to adopt coinsurance for nongeneric prescription drugs as are only 20 percent of other Massachusetts employers because information is readily available on drug efficacy and the dialog about drug options is one that is less complex for employee consumers to have with their physicians and pharmacists.

We intend to continue on this path but we will pace ourselves based on the availability and usefulness of sound and trusted health care consumer information and pricing transparency.

Choice is key to driving cost savings. We do not seek to limit options, only to have employees be educated consumers and accountable for their health care consumer decisions.

With that we think market forces will come to bear where improved value and lower cost is sought which will help drive efficiencies and improve health care outcomes.

On behalf of John Hancock I appreciate

this opportunity to share some of our experiences in managing our challenging health care costs, thank you.

MR. BURTON: Thank you. Next up Eric Michelson of Michelson's Shoes, Eric.

MR. MICHELSON: Thank you, I'm Eric Michelson of Michelson's Shoes, and we operate two full service family shoe stores in Lexington center and Needham center.

We employ twenty-four people ages seventeen to eighty-seven, many of them have been with us for over ten years, some for over thirty and in return for that loyalty and dedication we pay a hundred percent of our employee's health insurance premiums.

We have two problems with health insurance, our premiums are huge compared to larger organizations and our annual renewal increases are staggering. We've been quoted a 33 percent increase in our April 2010 renewal. When that occurs our premiums will have risen over 75 percent since 2004 and our insured annual out-of-pocket costs substantially increased also.

Currently twenty-one of my twenty-four

employees are eligible for coverage, we cover fourteen of them and the average age of our group is fifty-eight and a half years. Our insurance is a Blue Cross product called HMO Blue Deductible, which is a $500 individual, $1,000 family deductible. Prior to that we used a traditional HMO product and paid a hundred percent of the premiums.

In April 2009 we switched to a deductible product because of better rates and we continued our commitment to our loyal staff by funding a hundred percent of the deductible. Annual premiums for a family plan is currently $19,618 and will rise to $26,080.

Now a comparison, a forty-nine-year-old person can purchase an identical Blue Cross plan directly for $20,436. In addition, I have experience as serving on the Town of Lexington's Corporation Committee and one of our areas of research has been health insurance costs, and I'm comparing 2008 rates here but our business rates in that year were $23,210 for a family plan while the Town of Lexington covered the same family plan, same type of coverage for $17,441 and the state GIC was at 13,584.

My rates also have to be looked at in cost per hour per employee basis. Since the majority of our employees are couples on family plans, the deductibles and premium costs for us run from $8, $8.58 an hour to $13.02 an hour, that's on top of the salaries, an additional 12 to 42 percent increase in compensation.

This obviously will hinder my ability to hire new employees. I'm forced to make offers to new hires based upon total compensation and offering lower salaries in order to offset these premiums. My best offers remain thousands of dollars less in salaries than you get from a major chain store.

Finding more affordable coverage consumes dozens of hours that could be better used by running our business. We even looked into products offered through the Connector, but their improved pricing masks the highly limited networks these plans use.

We have also used every tactic possible. We have changed carriers to get new customer incentives, we've increased copays and we've gone to deductible plans. Mass Health Care Reform enacted in 2006 was supposed to favorably affect rates due to universal enrollment but instead of premium relief, we saw in 2008 renewal rates jump 25 percent and we had thought that we had seen the worst.

Last year the industry saw a deductible policy designed to save money by making consumers out of all of us. While we saved money in year one, year two brings on premium increases that total more than the salary of another employee.

I'm unable in this economic environment to even begin to comprehend how I'm supposed to absorb this cost to my business.

There are at least two bills working their way to the State House, House 4452 seeks to create an affordable health care plan and that is ultimately its downside.

The legislation favored by the health insurers create only one affordable option, a low premium, high out-of-pocket broad type plan that is inappropriate for middle to older age people, a plan I would not want my family or my employees to have.

House 3452 and Senate 446 takes a more effective approach to obtaining relief by allowing small businesses to join together to purchase insurance from a larger group, GIC styled insurance for small businesses that would offer multiple options, level the playing field between large corporations and small businesses.

It costs no more for the insurance company to pay for my employee to receive health care than an employee in a large corporation or a city or state employee or retiree, yet my employees are suffering because I lack the buying power to get them a fair deal.

In order to remain competitive and become the edge that drives the state's economic recovery, small businesses need across the board equity. Once our costs are the same as those large employers, a way has to be found to control and justify the double digit increases in annual premiums which is becoming the norm and not the exception, thank you.

MR. BURTON: Thank you. Next is Michael Widmer, president of the Massachusetts Taxpayers Foundation, Michael.

MR. WIDMER: Thank you, thank you for inviting me. As president of Massachusetts Taxpayers Foundation since 1992 I've been involved in a wide range of health care issues in Massachusetts, before that actually I was head of human resources for a major corporation in which obviously one of my responsibilities was health care.

I want to issue, or not issue, comment on with a voice of caution. I absolutely agree that there is a cost to inaction in the Commonwealth in terms of the escalating cost of health care, at the same time there clearly is a cost to misguided and precipitous action, so, I think the collective responsibility we have is to steer our way through those two polls.

Let me touch on three points that were in the, of all of the fantastic work done here by the Division, but first to underscore the obvious, the very first paragraph, health care is the state's top industry, the largest employer, Commonwealth Fund ranks Massachusetts first in terms of access to care, seventh overall in the state score card, Massachusetts hospitals are often cited as among the best in the nation in terms of quality and health care services provided, Massachusetts health insurers are consistently rated among the top ten best plans in each category nationwide, we all know that but it's not guaranteed so I just wanted to mention that first.

Secondly, a very interesting statistic here on page 7, namely that comparing Massachusetts to other states on per capita health spent as a percent of gross state product, Commonwealth ranks near the middle, 13.3 percent, interesting, near the middle and that adjusts for the wealth of the population which is I think a fair measurement.

Again, not to say we don't have a problem on health cost but I think that is an important fact. Thirdly, if we look at the most recent data, and this has probably changed since but I think it's nonetheless important, from 2007 to 2008 the adjusted growth in small group premiums grew 5.8 percent, midsize 4.8, large group 5.4, yes, a larger increase for the small group market but not a dramatically larger increase. Again, those are I think factors that one needs to keep in mind.

Let's look at the legislation and the potential legislative action in 2010, particularly focused on the area of small business and I agree, we do need to do something but again a balance. There are a number of options, a previous speaker already talked about some of them, but ideas about limited network, offering, requiring small businesses to have a limited network option, a semiannual enrollment period, the moratorium on the enactment of new mandates, these and other areas I think conform the core of legislation this year that will be helpful to small businesses in the short term, at the same time not have the kind of unfortunate unintended consequences of some other proposals.

I'm particularly concerned about the proposal from the Governor to have a cap on insurance premiums effective April 1. I don't think price controls over the years have been shown to be effective in addressing the underlying system and problems.

This is a particularly onerous version of that to jump into the market at this late date and to establish arbitrary premium caps, I think you will have all sorts of unintended negative consequences, exacerbate many of the problems and not deal with the underlying causes.

Two final comments, one is one of the problems we have here that needs to be addressed or at least raised and that is through every fiscal crisis, one of the ways we deal with a Medicaid problem because it's such a large part of the state budget and it grows as health care costs grow of course is that we cut payments to providers.

So, we have done that two, three, four times already and this will continue I will predict in the ongoing fiscal crisis which lasts at least through fiscal 2012, so, therefore, we're underpaying providers for the cost of public care that we ask them to provide.

That obviously puts pressure on the private side. Now, it's not one to one, there's a delay, but nonetheless one of the issues we need to collectively face is if we underpay on the public side, there is a consequence to the private side.

Finally, I'll close on a separate issue but absolutely critical and that is the soaring cost of municipal health care which is priced from municipal finances and it's been seen in that context, but I would urge us selectively to see that problem in the context of escalating health care costs for a major fraction of our population.

There are tens of thousands of local employees and retirees that are seeing huge increases year to year largely because it's impossible for local officials through the collective bargaining process to manage those costs.

One simple proposal which we strongly favor is to take the powers, give the local officials the powers of our health plan design outside of collective bargaining, the same powers the GIC enjoys for state employees and retirees.

We have documented that that would save an enormous sum for municipalities and would help bring down the overall rate of health care costs in the Commonwealth, thank you.

MR. BURTON: Thank you. Next Frank Romano, chief executive officer of Essex Health

Care, Frank.

MR. ROMANO: Thank you, I'll leave my testimony for you and just have a few comments off the cuff if I could. The first thing I want to tell you is I'm not an expert, so, I am nothing but an entrepreneur that started a company thirty-seven years ago after leaving IBM and we provide health care to seniors in Massachusetts.

I'm not sure that we're going to make the next five years if we cannot do something about increasing health care costs for our employees. That is clearly the struggle we're dealing with and I certainly empathize with my colleague to my left in trying to find affordable health care.

It's amazing to me that some of the issues that I see that we now have 97 percent of our employees insured, which is just wonderful, the trouble is we became self-insured three years ago in an attempt to reduce our costs from twenty-five years of Blue Cross Blue Shield and for a while things were looking good and then all of a sudden this last year our premiums went up 25 percent, so, we began to sit down and say what is going wrong with our numbers, where are we off.

Well, we found out that we exceed visits to the ER, our employees do by 50 percent over the national average. Now, we came to the simple conclusion that there's just not enough primary care physicians in Massachusetts with panels that are open to take our employees, so, they still go to the ER because now they have insurance.

We changed that this year by changing the deductible. We made it more expensive to go to ER, much less expensive to go to the doctor and an urgent care center, but it seems to me that the paraprofessionals, the nurse practitioners would move a long way to having access points to health care in Massachusetts, and there was a recent article, and I have copies for you, it says nurses covering more health care, it's about several states that allow practitioners to actually write scripts, and I'm sure you're all aware of this, but I think the nurse practitioner option to help physicians would be a great way to reduce the ER visits.

The other concern we have 50 percent of all our female employees did not get mammograms even though we paid for it, so, I began to study our numbers and I've come to the final conclusion we have to get more employee responsibility for the health care and to that I looked at life insurance policies. If you're overweight, you pay a premium, if you smoke, you pay a bigger premium, if you ride a motorcycle, you pay another premium, so, it seems to me until we get our employees actively involved in the cost of health care, we're not going to get this ship turned around.

So, I absolutely know right now today if you're a smoker and smoke one pack a day, at about 8.50 a pack, it's $3,100 a year, it's a lot of money, and I think the issue that we have to look at is how do we motivate them, and the only way I know how to do it at this point is if you're spending more money out of your own pocket for your insurance, hopefully you'll begin to look at stop smoking, taking our cessation program, going on some of the meds that do help you break the habit, but this is what we feel has to happen.

And then lastly, we have been working on an innovative program at a local hospital and our building in Milford, Massachusetts, all of our employees would go to the local hospital at a capitated rate. We would bypass, we use Harvard Pilgrim now as a TPA, we would bypass Harvard Pilgrim now and go direct.

All our employees have to use Milford Hospital, have to use their medical group and all the care would be provided by them and I would pay the hospital so much per month, but certainly that takes one more cost level out of what a TPA charges us to manage our care.

The trouble is convincing the hospital they won't get beat up in the capitative rate, and I've suggested we consider a reinsurance policy and assess it every year but then we're both in the same trap, they are trying to keep the cost down, we're trying to keep the cost down, but we're at that point.

I mean we are desperate trying to find solutions to where we are and especially from affordability and our employees can't take another hit. We can't go back to them next year and tell them it's another 24 percent increase even though we pay for a major portion of health insurance, that 24 percent to them is a large number. Thank you.

MR. BURTON: Thank you, Frank. Alan MacDonald, executive director of the Massachusetts Business Roundtable.

MR. MacDONALD: Thank you. Cost trends from the employer point of view, in the earliest days when we got employers fairly involved, there's so much change in our lifetime, certainly in my lifetime, it was not expensive to employers necessarily in the 1950's and 60's.

It really was only 4 percent or so of the gross domestic product that might have grown to 7 percent by the end of the 60's, but it was passed through to the consumers, and we had a very strong U.S. economy at that time buying a lot of U.S. products in the 1970's, and I say this having worked for GE during the 70's and through the 80's, we saw a tremendous change in the economy where the costs were not passed through to the consumer because the consumer was buying Sweden, Korea, Japan, the world, and at that time we started on the employer side to get very concerned about the increases that we saw as the percentage of the GDP grew to the point that it more than doubled to where it was by the end of the 60's by the end of the century.

So, in the 1980's that's when the employers in my experience really got tuned in to trying to manage the cost trend which as we know is continuing, and to the earlier comments in a 2006 report we did at the Roundtable, we saw the average family of four health insurance policy to be over $12,000 in 2005, which at that time was about 13 plus percent of the median income in Massachusetts which is a high income, but the median income at that time was $90,000 which is a very high income but here was our health care being 13 percent for the average family of four contract.

10 percent increases per year would get that 20, 15 to $31,000 plus for the average health care contract which would be even if we had 4 percent growth of income which we are not having would be over 25 percent of the median income in Massachusetts.

That's the trend line we see, so, what were employers trying to do in the 80's and into the 90's, it was managed care contracts. We found that it was very successful to define a set group of providers and a set group of covered lives and predict ahead of time actuarially what the likelihood of how many mammograms, how many procedures would be done and pay upfront, very similar to the discussion now about global payment.

That wasn't universally popular as we know and didn't pan out for the reason that even employers in helping employees push out of network did go out of network and that caused us not to be aware of what the cost per procedure would be because we couldn't guarantee any certain number of procedures. That was an effort that was tried and not successful for the long term.

So, into the start of this decade we got much more into consumer directed health plans. I should say that part of what we tried in the 80's was changing insurers. We would change, employers would every couple of years another insurer and it gave us one or two years of savings versus the prior year but it was not a long term solution.

Looking for the long term solution we liked the managed care, that didn't stick, so, we have gone to what you just heard and will hear more of is the consumer directed health plans, which work, really work to convince, to get the employer employee relationship involved in a market related relationship so that the consumer, the employee would not have unnecessary health costs, avoidable health costs, inappropriate health costs.

When we say unnecessary, we mean those that haven't proven to be of value necessarily but a desire by the consumer because there isn't any economic impact to make that choice, but there would be a medical impact that would say if there is no value, you shouldn't necessarily have to make that choice, avoidable by using wellness programs or case management.

We found when we researched what helped us the most at the start of this decade was good case management of chronic illness so that people who were the most dependent on the health care system could manage their diseases the best and that had economic positive impact as well as health impact.

Inappropriate to us would be the wrong settings, a setting that didn't necessarily fit the procedure that's necessary or desired by the employee consumer.

So, those three things are very important in consumer directed health plans to involve the consumer, the employee in an awareness of the economic impact of the system and the correct use of the system.

So, that was a big move for us and we have found as we were asked to testify today what is most successful, and it's those kinds of approaches and it is true that a managed care approach economically is a very successful approach for us and if it relates to the global payments of circumstances that we're dealing more of today, that may be something that we would find to be very helpful.

We did over the years see the utilization of the system did cause us to see cost trends go up, we did see that the technology in the system did cause us to see the costs go up, but again, with the right consumer directed health plans we have found that that has helped us out in some control of the cost growth, some management of cost growth.

I would just say to what Mike Widmer said, and I'll close with this, that that part of the cost trend to us is consumer behavior in a positive or negative way, the system has caused us to look at the trends as we've seen the trend in the health care system grow as supply and demand have both grown together over time, the system has grown in subsidies of both private and public to be a very expensive system where we try to do as much as we can to each and every patient.

The difficulty as we've seen with the inability of the public pay to support the system because now the public pay as we know is more than half of the dollars into the system.

We've built a very expensive system, we're now trying to support it with Medicaid, Medicare dollars and very difficult to do and since we can't do it frankly in a very difficult economic time, we need to lean on the private side more to support the whole system.

So, it does require as we look at that trend for an ability for all parties to work together to see what we can do about redesigning the system enough to measure up with consumer directed health plans. Thank you, Mr. Burton.

MR. BURTON: Thank you, Alan. Last but certainly not least, Delia Vetter, senior director of benefits from EMC Corporation.

MS. VETTER: Thank you, it's a pleasure to be here today, and EMC is a global employer employing over 40,000 employees on a worldwide basis, about 22,000 in the U.S. and approximately 9,000 in Massachusetts.

Over the past eight years EMC has been on a journey of health care cost containment and the journey really encompasses engaging the consumer or the employee and the family member, so, driving partnership and health has been our motto at EMC and integrating technology to drive consumer behavior has been a component of our journey.

Over the past eight years we have launched a very sophisticated health education program, health management, not health care education program because we understand that employees today understand the difference between an HMO and a PPO.

Certainly it's about health management. When we looked at our costs eight years ago, it became clear that if we did nothing, our costs would increase in five years, and we took that responsibility very seriously because the costs would increase not only for EMC, the company, but for employees as well because as we all know, employees share in the cost of health care.

And driving cost containment to EMC is driving good health and helping employees and family members engage in healthy lifestyle programs, so, at EMC we didn't take, we didn't develop the programs arbitrarily, we looked at data.

In order to develop the right programs that are targeted and meaningful to the individuals so that the individual will engage, they need the, the programs need to be meaningful and looking at data on the aggregate we can clearly see where the areas of need or of concern are within our population.

We developed programs on a regular basis and offer these programs, health management workshops to our employees and family members on a monthly basis based on the trends that we see in the data and we have very high engagement in those types of programs.

So, that's what I call the high touch of our component of our strategy. Now, the high tech component of our strategy is integrating information to drive consumer behavior by collecting information through a third party in a data warehouse and providing our employees and family members with a personalized health portal, that's personalized to the individual based on the information, on the claims information that's transmitted from the data warehouse to the health portal.

That health portal then drives targeted and meaningful messages, leads employees to programs that are available at EMC and it also provides a patient's safety component because within the health portal there's a personal health record that's collecting information or utilization on prescription drugs that are being purchased by the patient or by the consumer and it also, that type of health portal looks for drug interactions and sends alerts to the individual if there might be drug interactions.

So, it's also a patient safety portal as well and it helps employees look at the best hospitals potentially for elective surgery based on Leapfrog standards or quality outcomes, so, at EMC providing or containing costs is about managing health, not shifting costs to employees.

Over the past five years we have managed our success of our programs in driving partnership and health and from a cost containment perspective, approximately 112 million dollars in cost containment within a five-year period.

So, our trend, we're measuring our success based on our trend, we are self-insured, compared to the national average and on an average cost per capita we would have calculated 112 million dollars worth of cost containment. It's never savings as you know because health care costs continue to increase.

We have a very engaged population, the tools of the personal health record introduced in 2004, which EMC was the first employer to introduce a personal health record, and initially I have to say that employees were a little nervous about privacy but five years or six years later we have very good engagement.

About 50 percent of employees at EMC are using the personal health record and our goal through marketing efforts is to get that to a hundred percent. Our interactive health portal, we have 90 percent participation in the health portal and completing a health risk assessment is more than just completing a health risk assessment and maybe getting a report that helps you identify areas that you might need to focus on, it also provides us with aggregate information to help us better understand our population on a very proactive basis.

So, looking at the population very proactively through the data on the health risk assessment, looking at areas of risk and also looking at the claims information on the prospective basis to help us drive the right programs.

And one more point is that the information that's collected and that's shared with the interactive health portal, the interactive health portal is populated based on the information that's being, that's transmitted from, from the data warehouse, the claims information.

So, at EMC we have high engagement driving partnership and health, Health Link which is our health portal is a household name, and that's very important because as employers many times we roll out programs and we'll roll out tools and they lay idle.

At EMC we're very active in managing and employees are very active in engaging. We have high satisfaction and we are according to employees through a survey that we did through our health care partner, Excellent, we are, EMC is a trusted source for employees.

So, employers have a very unique opportunity to help drive good health in the Commonwealth of Massachusetts and within the employer setting, using the right tools and the right data to drive the right behaviors and the right engagement, and ten years ago, twenty years ago, employers took a very passive approach in the health plans.

We really left it to the health plans to manage cost and to manage health, but today it's a new era and employers need to be very actively involved in managing their cost because it is their cost, whether it's paid through premiums or through a self-insurance model, it's still the employer that's paying the majority of the cost, so, the active involvement, collaboration and coordination models, all stakeholders, that includes employers, the health plans and employees we feel is what will drive health care and cost containment and good health in the Commonwealth.

Thank you for the opportunity to speak to you today.

MR. BURTON: Thank you very much, Delia. My first question is I want to acknowledge I drive onto the Maine Turnpike from time to time to buy a shirt at LL Bean instead of the local big box store, I'm curious under the assumption that there is a correlation between cost and quality.

I was wondering if the panel members would react to the Attorney General's report in this major finding that there is none in terms of the way health care providers are paid.

As business people does that surprise you or how do you react to that, what forces it might unleash? Alan, you look like you have an answer.

MR. MacDONALD: It's not surprising to me actually, there is different price items for everything on the market. What we had a hard time doing is defining a market that differentiates the product to go with the pricing differentials. I mean there are price differentials in every product.

We don't look at health care as a commodity like a box of Wheaties or whatever that's going to be the same everywhere you go, it's going to depend on a number of things, the level of expertise, the overhead and every other thing that relates to an individual provider, but the very transparency is the magic word but the very awareness among the consuming public of what the differences in pricing and quality is what we're trying to drive towards because that is a very important thing.

MR. BURTON: Michael, would the Taxpayers Foundation be surprised to find out the taxpayers are paying more for a product that the Attorney General doesn't feel is greater quality?

MR. WIDMER: No, not at all, though I have not seen any evidence of that until the

Attorney General's first-class analysis that laid it out. I mean as Alan suggests, I mean you've got vast differences in price and quality in almost all products so that's not surprising.

Market leverage is part of what the economic system is about whether we like it or not like it, so, I think in this case we're not talking about a product whether it's an option to buy or not, we're talking about health care, so, the seriousness of it is much greater, and therefore, the question of how are we going to address market disparities becomes more, more crucial.

But I think it's very complicated, the thrust of my earlier comments and I think we can legislate the reduction of market disparities in a simple fashion, and that's the Attorney General has not recommended that and I think they repeatedly say they're not recommending that and I think that's important because in this case I think the quick fix will in fact make it worse.

MR. BURTON: I have a question for Delia, managing health seems very important to EMC, how do you know if it is working and the correlating question is is percent of the parties is down or is the average use down?

MS. VETTER: I'm sorry, what was the last part?

MR. BURTON: The question after that was is the percent of high users down or is average use down?

MS. VETTER: Right, so, the, we know it's working I'll say probably in three different ways, we're measuring our success again on the average cost per capita of our trend versus the national trend, that's one.

Two, we have some unique programs through a partnership with Boston University School of Medicine, we launched a program called the DASH program, which is a dietary approach to stop hypertension.

It was actually a clinical study and our employees, that was our very first program and employees that participated in the program that were hypertensive and participated in the program for two years and there was a claims data that we or actually an external party could track.

We saw a savings of nearly a thousand, a savings in cost containment, both together nearly a thousand dollars per individual that were in the program, so, managing hypertension just through a scientifically based nutritional program worked, so, that's one metric.

Recently with the Centers for Connected Health we launched another pilot program called the Smart Beat program which was a remote patient monitoring through a Bluetooth device, employees would take their blood pressure that were hypertensive, there was a control group and intervention group, 400 employees and those that participated in the program and followed the direction of the clinician we saw a drop in their blood pressure, and when we looked at that program, we're still calculating the ROI, but it could be about $2 for every dollar spent.

So, those are the two programs that we measure that weren't arbitrary that were actually measured with data and then our trend.

MR. BURTON: Thank you. Getting back to the previous question, if there is no correlation between cost and quality what motivation does an organization have to improve quality? Alan, would you like to?

MR. MacDONALD: Well, I, the motivation and patient safety and reputation of the provider for sure, but I think quality is going to be related to cost and that's what we'd like to get to.

You know, we look at any provider and there are no two that are identical, so, every provider needs to reach their overhead of what they're providing.

They may have a different combination of procedures A, B and C compared to somebody else, it's also got to get to their overhead, so, we do see as in every other market there are going to be differences in prices but they should very well relate to quality for sure.

So, I think from the provider point of view they must in their mind relate to quality but to the consumer they're going to relate to quality, convenience and other things that is true in other markets.

MR. BURTON: We'll have to invent a new system, the DQM, we'll call it T leverage -- okay.

MR. WIDMER: May I ask?

MR. BURTON: Sure.

MR. WIDMER: Add something, I think across this state whether you look at insurers, providers, employers, consumers, there is an enormous collective investment and focus on improving the quality of health care in this state.

So, I just want to and everybody in this room, almost everybody in this room is involved in one such effort or another, so, I don't want any suggestion that somehow quality is diminished in terms of the reality of what's happening in this state and the extraordinary focus on that among all parties.

MR. BURTON: I think it's important to note that the Attorney General very clearly, the quality is high across the board, she was very clear about that but this is an interesting, I do -- Frank.

MR. ROMANO: Question, the Attorney General gave us the raw data, I'm interested in what consumers perceive, do they perceive that community based hospitals and hospitals in general or do they perceive the Boston teaching hospitals have better health care, has anyone done that study to look at what consumers' perception is of quality of care? I'd be curious to see what that data that came up that correlated against your hard data.

MS. COAKLEY: We haven't done that study.

MR. BURTON: If there is no correlation between price cost and quality what are we paying for? Maybe have Frank or Eric.

MR. MICHELSON: I mean what I took away from the Attorney General's talk was that the same falls on us as falls the providers, it all comes down to leverage.

I see firsthand what the lack of leverage costs my business every year in both the baseline premiums and the growth rate of the premiums and I just feel that, you know, I'm not providing my employees what best they can get because I don't have that buying power.

MR. BURTON: I'm curious, Peter, you have tremendous market leverage as one of the largest insurance companies, do you have the same leverage in the health care market when you go out to purchase?

MR. MONGEAU: I think our success isn't so much a result of our size, I think it is a result of what I shared in my comments, that we have a focus and a collaborative focus with the health plans and looking at pilot, pilot programs and testing them to see whether they have an impact on our employee health and productivity and then continuing with those, and I think it's that spirit of partnership that has been more successful than the fact that we're a large employer in the state.

MR. BURTON: Any further thoughts on what you've heard?

THE AUDIENCE: I just have one question, you said you have 40,000 employees and I assume some of them are in other countries.

MS. VETTER: Yes.

THE AUDIENCE: Is there any comment you would make about your program with those purchasing health care in other countries and how that, you know, how those systems are used, you know, what, what those employees, how they respond to them and is there anything that sheds any light on what happens, what's the difference between there or any of them and us?

MS. VETTER: Yes, that's a good question, so, we focused over the past eight years, really focused in the U.S. because abroad as you know it's so, it's so difficult all of the different laws and regulations and so forth and we do have a very high population abroad, but I will say this, Canada is our next target.

In the U.S. once we've stabilized the employee population in the U.S. and the cost containment, we'll move to Canada and also internationally.

We had other employees that, we all share the same E-mails and oftentimes we'll advertise or market health management programs or we'll talk about PHR and an employee from Sweden, this was a true story, was visiting and said hey, how come I don't have that.

So, they're starting to think about different tools and different programs, so, eventually over the next maybe five to eight years we'd like to expand abroad, but again it's a bit more difficult and it's expanding not on purchasing, it's more on the health management and creating that same type of philosophy and strategy as in the U.S.

MR. O'BRIEN: I have a follow-up question, you mentioned and I think a number of the panel have talked about case management and failure to have sort of preventive care, have you found through your work that the shift towards preventive primary care has been the bigger percentage of your premium dollar than what it is nationwide?

MS. VETTER: Oh, to me, okay, well, what's interesting is on the preventive care, the data indicates to us that preventive, our employees were very good at preventive care, 12 percent of our health care costs are on preventive care.

So, I don't think there's been any increase in preventive care, what we see is better management of chronic conditions, okay, so, we see much more active management of chronic conditions versus just an increase in the preventive care.

MR. O'BRIEN: And as far as lessons

for other employers both on getting to be good at primary care and managing chronic conditions, are there takeaways, is it data driven or are there other takeaways that the other employers can learn from your experience.

MS. VETTER: Yeah, it's data driven. Looking at the data, we understand and it's been published that 50 percent of health care costs are attributable to lifestyle modification and looking at the data such diseases or conditions such as hypertension and asthma and so forth, circulatory type of conditions, managing those conditions are as key to containing costs and driving good health.

So, as an example, at EMC when an individual takes a health risk assessment, if they've been identified at risk for a particular condition or if they self-disclose a particular condition, that information is shared with lifestyle coaches and there's outreach, so, lifestyle coaches will reach out to the individual and get them engaged in a program, so, the data is key to driving our success in our programs.

MR. BURTON: Would your business or

businesses that you are familiar with be open to considering use of such strategies as limited network plans that encourage use of lower cost providers, tiered network products, small group purchasing via an exchange or cooperative such as a Commonwealth Health Insurance Connector and there was a corollary question, as employers do you think your employees will be satisfied with narrow network projects given the conclusion that there is no difference in provider quality?

But the main question is would you be, are you familiar with and considering these other three strategies, limited networks, tiered networks and small group purchasing.

MR. MONGEAU: As far as the first two options, yes, it is something we would consider and I think I would want to add to two earlier questions and kind of weave them together.

By way of the data that is currently available, although it might be disappointing with respect to cost and quality, we're very encouraged that it's a baseline, we have a starting point in which to build and I think that that is a huge success.

With respect to what makes the programs successful and what would make the two programs that I said we would consider successful on a go forward basis is they need to be data driven, sound data driven but another element and what has made programs successful is we're dealing with consumers.

So, communications, branding, culture are all critical and these are elements that a company can bring to the table effectively because of some of the inherent nature of the way a company operates, so.

MR. ROMANO: It's interesting, I think larger companies have a great advantage and I think some of the things that they are both doing is wonderful, but when you get to be a smaller company you don't have all those resources, and it seems to me in Massachusetts, when you're speeding, you get a ticket, your premiums go up for the next three years I think, and I envision two employees in our company, one paying half the amount of another employee if they don't smoke, if they're not overweight, if they take their health assessment, if they do their yearly physical.

So, I'm going back to fiscal responsibility of the individual employee. Forget motivating, I'm going to motivate them with dollars. As an ex IBM salesman, that's what motivated me was how did I sell.

And so, my feeling is if you want to live an unhealthy lifestyle, you're going to pay for it. If you want to, you know, do something else that's the way it is. That's what happens I guess when you're an ex Third Marine Tank Commander in Vietnam, you know, what are you going to do, I just tell you I came out of that background.

I mean at this point I'm so frustrated with trying to get it to work that I have to do something or I'm not going to be here five years from now and I've got to figure out how to do it.

MR. BURTON: Why am I not surprised you were a tank commander. I had Delia was responding to that question and then Alan.

MS. VETTER: Yes, just in response to that question and another comment, on price transparency which is very important to the consumer because we know that they are not aware of what health care truly costs, and so, price transparency at EMC is now available to employees, through the personal health record employees each time their office visits and their diagnosis, all the information is transmitted into their personal health record, they can see how much that that care actually costs and I can tell you that it's an eye opener.

We have had individuals that have looked at their personal health record and they've seen that they've spent out of pocket for a copay say at a hospital $250, and their surgery or their procedure was 50 or $60,000.

So, think of the price transparency is so important to increase the value of, the procedure value of employer sponsored health care, so, price transparency is key, and in response to your question on the tiered networks, yes, we would consider tiered networks because we feel that too that employees are shielded from the fact that every provider is equal and we know that that is not true.

MR. BURTON: Alan.

MR. MacDONALD: I was going to say

yes, a tiered situation, we did a report in 2002 which looked at the fact that quality care at an appropriate setting where you would say whether it be community setting or a health center, health clinic versus what would be a more expensive level of treatment for the same result, we said to ourselves at that time if you could have the chooser choose a more expensive setting for the similar result, they ought to pay at least part of the choice, that we would never want to deny anyone the opportunity for the same result at an appropriate setting but we also wouldn't want to deny choice.

So, if somebody wanted to do that in a system that is subsidizing everything, that they ought to pay for it themselves. That's why we weren't surprised at the differentiation on the price because demand is what dictates price a lot of times, quality we assumed to be very good at the lower price level, we find that to be true, but price relates not only to quality but demand.

And so, when the product is subsidized demand goes up of course and we subsidize in our system everybody from the highest income earner to the entry level position on the same policy, so, why would we expect any different in their behavior with that kind of subsidy, but if we say that those who can afford to make the choice, bless them and let them make the choice but let us not have to subsidize the choice that someone makes that they can afford for the same result at a lower level, so, we're all for that system.

MR. BURTON: Eric.

MR. MICHELSON: The limited network idea, that's a drawback especially with middle and older aged employees because they have developed great relationships with doctors.

I mean the first question my wife asks me when I come home and say we're switching insurance again this year is well, are the kids' doctors on the plans, you know, is my doctor on the plan?

So, it really, we have to look at these things very carefully and we actually took a good look at the Business Express program offered by the Connector and found that the majority of the doctors that we were currently seeing weren't covered in the networks and some of our employees have long-standing relationship with specialists that weren't covered.

So, at this point in time, at this point in the system going on a limited network is very difficult for us. Tiered plans we would consider, smaller groups we would consider also, but going back to the discussion we were having about the fact that these programs contribute better to your cost control than the leverage or the size of your group, as a small business I don't have the overhead, I don't have the staff, the time, the critical mass of employees to roll out wellness programs or these great programs that Frank and Delia talk about, I mean Peter and Delia talk about, but I would love to have my employees be able to avail themselves of that and get cost savings but that would fall into the hands of my employer, I mean on my insurer, so, it's a real problem.

MR. BURTON: The report opines that businesses across all categories are reducing the size of benefits, if this is the case for your business or businesses you are familiar with how have your employees responded?

I might answer myself, I'm in the Mass.

insurance state system and we did have our benefits reduced and there was some reaction but like Michael said, the way that the state plan works is it's not subject to everyone in the system but took a higher copay simply to keep the system solvent.

Have you had experience with this in your businesses where you reduce benefits as the report has said and what's the reaction?

MR. ROMANO: Honestly employees don't like it at all and it is a real issue and they are very upset over it. I mean last year we wiped out chiropractor services as part of something covered because we wanted to save money there.

It is difficult. Employees today see that they are paying, many companies are asking the employee to pay more of the health insurance, so, I see it as a real problem and we have to find a better way.

We just can't keep cutting and asking to pay more, that's just not going to work.

MR. BURTON: Other panelists, Peter.

MR. MONGEAU: We have had actually success, we've been fortunate that the changes we've made to our health plan have not been drastic and they have been ones that are in line with what I have spoken about in particular with respect to trying to weave in some element of accountability when the data is there for employees to make wise decisions.

We also look at the total deal for our employees, so, that we're conscious of what we pay, the culture, the organization, et cetera, and our survey data actually indicates that employees are quite satisfied with what we are offering, benefits and else wise.

MR. BURTON: Delia.

MS. VETTER: Likewise, at EMC we've been very fortunate that we have not increased copays or deductibles since I think it was either 2004 or 2005, so, each year we continue to again just to focus on the cost containment on the health management, we've increased employee contributions in the single digits while we know that other employers are increasing in the double digits, so, similar to Peter we have had very good success and have not had takeaways.

MR. BURTON: Last question, what

impact do you think transparency of quality in cost providers would have on your business or businesses you are familiar with, what specific kind of information on price and quality would be most helpful to you in considering benefit design or benefit purchasing, anyone? Don't speak at once. Yes, Frank.

MR. ROMANO: I think it's great, I mean I think employees, if we did a study on what employees think, I think they think some of the teaching hospitals provide better health care.

Once they understand that the local regional hospital can provide good health care to them at a better price, then I think that's a big win, so, I came away with that today.

I've got a piece of data now that I can talk to my employees about and let them understand that that perception isn't always the case.

MR. BURTON: From the nodding heads I take it the rest of you agree with that. Any further comment on that? I can't conclude without mentioning, in deference to what Michael said, that all of the chambers are supporting paid plan design for the municipalities right now which is a tough situation, but I think as Michael said it's a critical area now and it's going to be a tough issue but that's where the towns get to design the plans for their employees and millions of dollars I understand, Michael, would be saved due to that method.

MR. WIDMER: Well, yeah, save tens of millions of dollars and it would compound over time, but the other thing to underscore is in the legislation, there would be protection that the plans would be no worse than if you will or on a par with GIC, so, that the notion that somehow you're going to, some town will just basically jettison health care benefits for employees and retirees would not be the case.

There would be a protection because even with the changes in the GIC, the state employees, retirees, it's a very good plan, so, that protects you there.

MR. BURTON: Unless there's any further questions or comments, that concludes this panel. I'd like to thank profoundly our panelists today for taking time to come in, and thank you all very much.

(The audience applauded.)

MR. MORALES: Thank you, and we're going to take a ten-minute break and come right back.

(A break was taken.)

MR. MORALES: And I'd like to invite Commissioner John Auerbach, Commissioner of Public Health, to the podium.

MR. AUERBACH: Thank you, Commissioner Morales, and thanks to all of you who have stayed throughout the day and are still here to hear the testimony of this important panel.

I want to in particular thank Commissioner Morales for including the voice of the consumer in these three days of hearings and thank you for your leadership in terms of ensuring that consumers are a part of the process, that is important because fundamentally, health care is about meeting the needs of the consumer of care and it's the patient who benefits when care is both high quality and accessible and it is the patient who suffers when care is neither of those, and consumers in fact do care about costs for many reasons, those include such things as the impact of the cost of premiums, the impact of copays and deductibles on the one hand and it also, consumers care about cost also because of cost related decisions that may affect them, such things as limiting the benefits that are available to them or limiting the providers or the facilities they can visit are all related to costs, and consumers also are, approach the issue of health care not just in terms of clinical care in a narrow sense but they're concerned, we're concerned as patients with our overall health, overall wellness, and therefore, take a broader perspective on thinking about this issue and think about all the conditions of our lives, not just the clinical visits that do have an impact, and some of those conditions of life often called the social determinants of health, patients understand have a critical role in terms of complementing what takes place in the clinical settings.

And so, not surprisingly since consumers and patients care about cost, consumers and patients want to have a role and a voice in shaping policy and in determining their premiums and the way the care is delivered.

So, to discuss all of those issues I'm delighted to introduce the esteemed panel that you see before you and following the format that was used in the last panel, I'll be introducing each one of the panelists one at a time, they'll speak and then following each of their presentations we'll engage in a question and answer period.

So, the first person who will be speaking is known to many of you is Amy Whitcomb Slemmer, Amy is the executive director of Health Care for All, Amy.

MS. SLEMMER: Thank you so much, Commissioner Auerbach, for facilitating this panel. Health Care for All is pleased to participate in these hearings and we commend the Division of Health Care Finance and Policy for their exemplary work in producing the detailed cost trends report and for their dedication to transparency and for organizing today and the rest of the week, thank you so much.

Health Care for All is a nonprofit consumer advocacy organization dedicated to creating a consumer center health care system that provides comprehensive, affordable, accessible competent high quality care and consumer education for everyone especially the most vulnerable people among us.

Much of HCFA's work is conducted through state coalitions, and we convened the Massachusetts Coalition for Better Care, a broad network of consumer organizations working together to achieve comprehensive payment reform.

I'm pleased to be joined by a number of our coalition members this afternoon who will speak on their own behalf but also some for their own individual organizations.

We believe that it is imperative that we tackle the cost and quality challenges in our health care system as quickly and effectively as possible. As we know that thousands of consumers are struggling to pay for their annual premium increases in order to maintain access to our world renowned and expensive health care system.

The cost trends report highlights the fact that health insurance premiums and the price of medical care are escalating at an alarming rate. As you gather testimony this week, we urge everyone to remember that it's the Massachusetts consumers who shoulder the brunt of these ever increasing costs. We strongly believe that consumers must be at the center of any conversation about health care costs and propose policy solutions.

Our work on cost and quality is shaped by help line callers like Melissa and Tom, a couple who opened a small business in 2008 and thanks to our health reform law qualified for affordable and comprehensive health insurance through Commonwealth Care. Their two young daughters receive their care through Mass Health.

By the end of their first year in business Melissa and Tom had earned $70,000 which is a success in any economy but a remarkable achievement in our current circumstances.

Unfortunately, it was also more than the allowable limit for a family of four to qualify for the sliding scale premiums and that they depended on to pay for their health insurance.

In order to retain comprehensive coverage, Melissa and Tom's premiums were quoted to be $12,000 a year which was a quadruple increase in their cost they paid under Comp Care, and even with a tight family budget absolutely this number and cost was unaffordable, so, this Massachusetts family is currently uninsured.

The preliminary report released by the Attorney General on cost trends and cost drivers found that our competitive marketplace is not operating in a fair and balanced way and that market mechanisms are not serving public needs.

I'll quickly highlight four areas of concern and related opportunities and we will fully agree with and endorse the points that you will hear from the other consumer representatives this afternoon.

First of all, consumer engagement can lead to lower costs and better quality. The most critical component necessary to containing health care costs in a sustainable way is to engage consumers as partners in their own health care.

We know that there are innovative programs that have demonstrated increased patient skills and lower overall costs and we believe we must revise our payment system so that programs like these are supported to improve the quality of care, improve patient satisfaction and lower overall health care costs.

The second thing we believe strongly in is that transparency is a prerequisite to effective oversight, patient understanding and public accountability.

We strongly urge policy makers to expand public transparency of our health care payment system. The AG's report indicates that there are supplemental payments from insurers to providers that are not related to patient volume, patient acuity or meeting other health care quality standards.

We welcome public scrutiny of these payments in order to better understand how they benefit patients. How many times have we heard the patients have no idea how much our tests and procedures cost.

We urge the Division and other state agencies to fully disclose complete information on prices, contracts and financial arrangements in our health care system.

The third thing we feel strongly about is that cost reduction and quality improvement can be achieved by rewarding coordinated care. Our current payment structure rewards quantity of service and not quality.

We are endorsing the eventual elimination of payments for unnecessary duplicative tests, preventable hospital readmissions and medication errors. These efforts are of no value to patients and cost our health care system necessary dollars, dollars that would be better spent incentivizing providers to keep us well and out of hospitals.

We want all Massachusetts residents to receive the health care they need when they need it. This care must be coordinated so that everyone is kept healthy as possible and not just patched up and sent on our way until the next acute episode.

Fourth, we believe an expanded investment in public health and public prevention programs can also reduce overall costs. The health care quality and cost roadmap to cost containment emphasized the critical role that public health plays in addressing overall health costs.

We endorse community and employer engagement efforts that focus on improving our health like increasing walkable schools, school routes as well as key regulatory changes like nutrition labeling, and finally, we believe strongly in the investment of public health campaigning like substance abuse prevention in as cost effective ways in attributing overall public health and thereby delaying and reducing the dollars needed for our health care.

We think that investments in public health pay long term and wide ranging dividends throughout the Commonwealth and believe our current public health spending must be increased as a vital part of payment reform.

Health Care for All looks forward to working closely with the Division, the Attorney General and other state officials on health care cost containment and quality improvement efforts. With Chapter 58, Massachusetts pioneered health care reform. We showed the nation how we could expand coverage to almost everyone in the Commonwealth.

Now we have the opportunity to lead the way by taking bold steps to control the costs and improve the quality of care that our health care system delivers. We know that the Governor and this administration are committed to this goal and we pledge our best efforts to make the changes that are needed to serve the interest of patients who must be at the center of this next phase of health reform. Thanks very much.

MR. AUERBACH: Thank you, Amy, for that presentation and for the brilliant observation about the value of public health.

MS. SLEMMER: I liked that.

MR. AUERBACH: Our next speaker is Deborah Banda, Deborah is the Massachusetts state director for the AARP, Deborah.

MS. BANDA: Thank you, AARP is a membership organization for people over the age of fifty and we constantly hear heartbreaking stories from our members. We know that the cost of health care is one of the most important personal and economic issues they're facing right now, not only for themselves as aging Americans but for their children and their grandchildren.

I'd like to tell you just three quick stories to sort of put a face on what it is like for these folks. Ann is sixty-three years old, she's self-employed and she lives on the Cape.

She buys her health insurance through a small group. In 2002 her premiums were $400 a month and that sounds very bad. This year they're $1,059 a month.

She is healthy and she takes no medications. She told us just yesterday that she's considering reducing her coverage to something more affordable. She also told us that she's thinking of moving out of the country because she just can't afford to live here anymore and have the health insurance coverage she needs.

We heard a similar story from a sixty-three-year-old Danvers woman and she told us every time she thinks about what it costs her to stay insured, she feels like she is being hit in the face.

Another story, Pat from Salem is fifty-nine, she went on Medicare early because of disability. In 2008 she and her husband spent nearly $15,000 on out-of-pocket health care costs. She told us it's a struggle and I think that's probably a massive understatement on her part.

I have filed much more lengthy testimony but I want to briefly confine my remarks today to two areas of particular concern to our aging population when it comes to confining costs and which are critical, namely, the role of better care coordination on reducing the need for institutional care and also the need to support family caregivers.

Better care coordination as Amy indicated is critical to reducing costs while improving quality of care and quality of life for those folks with multiple chronic conditions.

It's especially important to older adults who are more likely to have chronic conditions and who are likely to have family or other informal caregivers who are struggling to help them.

Good chronic care coordination can help keep individuals out of more costly institution settings and providing the supports to live independently can help delay or prevent institutional care.

Supportive services or home and community based services can often be provided more cost effectively than care in an institution setting. For example, some of our research shows that on average Medicaid dollars spent on home and community based services can support nearly three older adults and individuals with disabilities for every person at that same price cost for a nursing home.

Other recent research indicates that states that make long term commitments to increasing home and community based services while diminishing their reliance on nursing home services can realize long term savings; however, we know that such a commitment requires short term transitional costs that states can have trouble paying for right now especially in these tough economic times.

Enhanced federal Medicaid matching funds for home and community based services could provide the incentives to make short term investments that result in long term budget savings and improve lives for older adults and people with disabilities who need these services.

Now, keep in mind that family caregivers are often critical parts of an interdisciplinary care team helping to meet the needs of an individual with multiple chronic conditions; however, we also know that caring for loved ones can take a physical, emotional, mental and yes, a financial toll on caregivers that is very well documented.

To continue in their caregiving role and to help ensure the provision of quality care and reduce costs to the public and private payers, caregivers need additional support.

It can come in a variety of forms, it can come as an assessment of the caregivers' needs to help them connect them to services such as information and training and respite care, better discharge planning, navigational assistance and information about providers so as to make the best decisions about care options, better communications with providers as part of the care team and also support from nurses and social workers.

AARP has estimated that the economic value of family caregivers' unpaid contributions to be about 375 billion dollars in 2007, so, supporting these folks is not only the right thing to do, it is also the smart thing to do economically as well.

So, we urge the Commonwealth to adopt

policy recommendations that initiate cost containment measures that effectively constrain growth in price, volume and intensive care services without compromising quality of care or inappropriately denying access to care.

We must ensure that cost containment efforts do not result in efforts to shift costs inappropriately to patients or other payers and we urge you to develop policies that initiate tests that evaluate payment approaches that create incentives for providers to be more efficient and more effective and that reward good outcomes, thank you.

MR. AUERBACH: Thank you very much, Deborah, and now I'll introduce Matt Selig who is the executive director of Health Law Advocates, Matt.

MR. SELIG: Thanks, Commissioner. I just want to start by thank you very much, Commissioner Morales, and his staff at the Division of Health Care Finance and Policy and the Attorney General and her whole staff for all the effort they did putting together all the incredible research that went into this, the background for this hearing. I know that they did an incredible job and I also want to thank the Division of Insurance and the Department of Public Health for all the work they've done as well, and it's really a huge privilege to be up here with all these incredible advocates up here, they're all wonderful.

My name is Matt Selig and I'm the executive director of Health Law Advocates, which is a nonprofit public interest law firm that provides free legal services to low income Massachusetts residents having trouble accessing health care.

We help nearly a thousand low income consumers each year. Much of our work involves helping consumers obtain insurance coverage for their health care. We also handle many cases involving clients who have medical bills for which no insurance coverage is available.

What we see every day are consumers who have enormous medical bills that they can't afford. They're afraid to go in for badly needed health care because they're scared to get more health care bills and their lives have turned upside down because of the cost of health care. They lose any savings they may have, they lose their housing, they drop out of school and their credit is destroyed.

I'd like to describe one case that's very typical of the situations we encounter. We were contacted by a forty-three-year-old-man from Boston I'll call Peter. Peter has dealt with health issues his entire life.

He has congenital heart problems that lead him to get a pacemaker when he was seven, he suffered a stroke at a young age and has frequent seizures since. A few years ago Peter was working and earning about $20,000 a year and he had health insurance through his job which paid for about 90 percent of most health services.

At that time Peter went in for services at a Boston hospital and also needed emergency care by a hospital on the South Shore at a time close to that. He ended up with hospital bills for about $1,600 from both institutions, but Peter's income was only enough to cover basic living expenses so he had no way he could pay these bills.

Both hospitals referred the bills to collection agencies which reported the debt to credit rating bureaus. Neither hospital advised Peter to apply for the Health Safety Net program that would have covered the hospital bills if Tom had applied even within a few months of the services.

HLA attorneys contacted the hospitals on Peter's behalf and after they examined the case the hospital in Boston agreed to forgive the bill for $1,600 and their collection agency promptly removed the debt from his credit report.

The hospital on the South Shore refused to negotiate and said they did not offer discounts to patients with insurance. The hospital also claims their policies made it impossible for them to remove this debt, the debt from Peter's credit report until he paid the bill in full.

Peter's in and out of work because of his health and simply cannot afford to pay these bills. HLA handles cases like this all the time and it illustrates the challenges consumers face with the cost of health care.

I chose this case really because it's not an outlier case, we do have cases involving tens of thousands, hundreds of thousands of dollars worth of debt, but this is a case where $1,500, $2,000 worth of debt which to a person with limited means is really an insurmountable amount of money to pay but yet the kind of case that we have all the time.

That's really all I have for now for my testimony, and in closing I just wanted to say that I'm look forward to participating in the dialog today and in the future with policy makers and all the other stakeholders in the health care system to find solutions to contain the cost of health care and improve the system for all participants.

MR. AUERBACH: Thank you very much, Matt. Our next speaker is Nancy Turnbull, Nancy is the senior lecturer on health policy and associate dean for educational programs at the Harvard School of Public Health, Nancy.

MS. TURNBULL: Thank you, Commissioner, I have to first note that I am having my time kept by someone who used to be a student of mine at the School of Public Health and

I just want to say to you I plan to ignore you as much as you used to ignore me.

I appreciate very much the opportunity to testify today about the consumer experience of advising health care costs. I want to focus my remarks on four different areas, a couple of which have been touched on by other people today.

The first is the corroding effect that rising health care costs are having on family incomes; the second is the jeopardy to health reform in Massachusetts of rising costs with particular focus on individual mandate; the fourth, the third is the opportunity costs of rising health care spending in terms of our ability to make investments in other important areas that would improve health; and finally, I want to end with the wisdom of Chicken Little.

So, the first point is one that Len Nichols made I think very well and that's the point that health insurance premiums are increasing faster than incomes which is creating a crisis of affordability for individuals and families.

In Massachusetts health insurance costs

are rising at a rate that's three to four times the rate of wages and I really commend any of you who haven't read it, there was a great consumer Commonwealth Fund report last year which I think summed up what's happening well which was called "How health insurance premiums are eating up middle class incomes."

Individuals and families are devoting an increasing share of family incomes to health care. This is making it harder and harder for people to pay for other living expenses.

The problem is compounded as we've heard today from a few people on the fact that health benefits are getting skimpier which means that people are not only paying increasing premiums and more expenses out of pocket and there's, there are a variety of research studies that show that rising health spending is making it ever more and more difficult for people to save, for people to save to buy houses, for people to save for college education for children, for people to save for retirement, so, lower savings rates that are being caused by rising health spending will have implications for decades to come and these problems are particularly acute in Massachusetts, where referred to today we have the highest health insurance premiums in the country and where household income is actually growing quite a bit more slowly than the rest of the country.

The combination of these two things is producing a situation which for me reminds me of a video game some of you may be familiar with which is called Pac Man or Pac Woman.

I actually would have done much better in college had I not become so acquainted with these games, but in Pac Man you may remember there are four characters who are called Inky, Blinky, Pinky and Clyde who are the only forces that can stop Pac Man's insatiable appetite for more and more Pac drops and energizers and fruits and power pellets, and I think we actually need to develop our own version of Inky, Blinky, Pinky and Clyde in health care.

Otherwise, pretty soon it's going to seem as if most people in the Commonwealth are working for health insurance wages as a fringe benefit.

So, the second point is rising health care costs jeopardizing health reform, we've heard that from several speakers today. The point about this I want to make is a somewhat different point and this comes from my perspective as a member of the Connector Board and board member, one of the things that the Connector Board has to do every year is set the affordability schedule and we did this last week at our board meeting and this is a schedule who determines who is subject to the individual mandate in the state and it shows different family configurations and different income levels how much we've decided is affordable for people to pay for health insurance or else pay the penalty.

Now, when health insurance premiums are increasing, that's for employer insurance, individual insurance or any other kind of insurance, the impact of the individual mandate, how many people are actually subject to erodes unless we increase the affordability schedule, so, since the affordability schedule was adopted in 2007, every year the Connector Board has voted to increase the affordability schedule.

We do it differently for people at different income levels, but if you want to retain the reach of the individual mandate, we have to do that with health insurance premiums going up, but although if you've ever been to one of our meetings, you know we have a lot of differences of opinion and philosophy about what's affordable in this state, I think the one thing that we all agree on on the Connector Board is the biggest challenge we face in setting the affordability schedule and reaching the individual mandate is how fast health insurance premiums are going up and it's simply not possible every year to increase the affordability schedule 8 to 10 to 12 percent.

So, if we don't do that, we will find that the reach of the individual mandate erodes and in my view it should erode for reasons of fairness and equity, so, finding ways to contain health insurance costs are very important to maintaining our progress in health reform.

The third point, and I hope Commissioner Auerbach will think that I'm as brilliant as Amy and others in making this point, is what economists call the opportunity cost of rising health spending.

For those of you who remember your introductory economic courses, opportunity cost is a fancy phrase that economists give to talking about what do we forgo when we pay for something in terms of what else we could have spent our income on.

If you look at what are called the social determinants of health and public health people, the economic and social conditions that determine the health of individuals and communities, you find that actually medical care is pretty far down the list of the social determinants.

There's lots of research that shows that while access to medical care is important to health, it's a lot less important than many other things, it's a lot less important than education, employment, income security, quality parenting and early childhood development, food, housing, social supports and all of the other things that determine the conditions in which we work and live.

So, as health care is consuming more and more and more of both our private and public resources, the consequence of that is actually probably reducing our health ironically enough, it's reducing our health by limiting the resources we have available for all those other important determinants of health, education, housing, income support, all the other things that I named, and the extraordinary state budget cuts to public health over the last few years I think are particularly disturbing in this regard.

So, access to health insurance and medical care are important, they're not the same as health and for me, actually the most critical, imperative to control health spending is to free up resources that would be much better devoted to education and public health and other social services if we actually want to get healthy.

So, my final point is what I call a lesson from Chicken Little. So, and this is the point that it's hard to find ways to control health spending and it's, there's a huge gap between what government officials and health policy experts and consumers think about how urgent it is to do that.

It is, and I think in fact Commissioner Murphy actually made this point very early, well and earlier this morning, most people with higher incomes, which I imagine probably includes most of us in this room, unless we work in this field we don't necessarily see rising costs as a threat to our own access, so, the issue of controlling costs probably not in our personal lives, maybe has not as much salience as it does for many other people.

In fact, I think as Commissioner Murphy said is the downside to this, but the point here that I want to make is I think for too long we've deluded ourselves that there are ways to control costs that don't involve sacrifice, that don't involve fighting, that don't involve hard choices, and some of the things that have recently been well talked about, ways to control costs.

So, I think they're important and I would put on this list, you know, eliminating waste and a lot of this talk about public reporting, administrative simplification, even Health HIT, all of these things are really important and I think we need to make investments in all of these things, but to me more to include the quality than to control costs because I don't think that any of these things are going to be the way to control costs.

I commend Commissioner Morales and his staff, commissioned a very good report by the Rand Corporation which is really an example of how many of these things that are getting a lot of focus, while they're very good to improve quality, it probably won't actually help us to control costs.

So, instead controlling costs is going to involve hard choices and political leadership, including less revenue growth and income for some providers, lower revenues, less profitability for health plans and probably less and different care for those of us who are consumers.

If you're as old as I am and maybe only Rob has been around this issue as long as I have, but since he's the only other one who has gray hair, it really feels like testifying on the need to control health care costs, you feel like Chicken Little, and for those of you who haven't read Chicken Little as recently as I have, Chicken Little was frantic to warn the king that the sky was falling and only an acorn was falling on his head, and that's what most of us remember about the tale of Chicken Little.

But to me the real moral of the Chicken Little story is a different one and it's really quite appropriate here, the moral of Chicken Little to me is do not be afraid and don't be a chicken, and I think we're at a moment in time when maybe the political forces have aligned and we're showing a readiness to attack this problem in a new and different way.

For some of us it's because we want to sustain the progress we've made on health reform, for other people it's for actual reform, for others it may be the only silver lining we can find in the fact that the economy is so terrible.

So, I really urge us to heed both the wisdom of Chicken Little and also it's actually the wisdom of Stanford economist, Paul Romer, so, he said a crisis is a terrible thing to waste.

So, I actually think we know what many of the things we need to do to control health care costs are, so, we really do know the health care version of Inky, Blinky, Pinky and Clyde, and I think we shouldn't waste the opportunity to do something big and bold and effective in controlling health care costs.

I would say consumers can't afford any more delays in doing what needs to be done, so, my fourth point is just let's not be chickens.

MR. AUERBACH: So, Dean Turnbull gets special credit for weaving in both Pac Man and Chicken Little into this discussion, thank you very much for that. And now I'd like to introduce Cheri Andes, Cheri is the lead organizer for the Greater Boston Interfaith Organization, Cheri.

MS. ANDES: Thank you. For those of you who don't know, Greater Boston Interfaith Organization, GBIO, is an organization of fifty-five other organizations, churches, synagogues, mosques, unions, community development corporations and some other creative institutions that come together to work on public policy issues, issues of justice, issues that our various constituents can agree are critical to the 55,000 people that our organization represents and we were proud and honored and excited to be partners with almost everybody, everybody on this panel, not everybody, everybody on this panel.

MR. AUERBACH: We'll talk later.

MS. ANDES: In helping to bring health reform to Massachusetts and in helping to implement health reform in a way that we felt would benefit our members and the society as a whole.

So, we're here today because we believe that health care costs like health care access is a justice issue. There's general consensus and I think we've heard it today among policy makers and consumers at large that as Nancy said, health care costs are growing well beyond the overall rate of inflation and people's incomes, three to four times the rate of wages and health care costs in Massachusetts are among the highest in the nation and actually the world.

The consensus around that, GBIO believes that this trend of out of control health care costs is in fact a moral issue, is in fact a justice issue and one that needs to be addressed out of that, that belief system.

We believe that out of control health care costs threaten the viability of Medicare and Medicaid to meet the entitlement needs of those groups, that's a justice issue. Rising health care costs mean that employers instead of giving wage increases have to dedicate these labor related resources to paying health insurance premiums instead, so, people aren't getting the kind of wage increases that they need to maintain, sustain themselves in this new economy, that's a justice issue.

The cost rises leads to government needing to scale back its payments to providers making such patients less desirable to be cared for by the doctors, so, people, especially Medicaid folks, have difficulty obtaining specialty care because no one will see them, that's a justice issue.

Providers because of the fee for service model are pressured to see too many patients in one day which can and does lead to suboptimal care, that's a justice issue. Access gains will be eroded.

We worry about the erosion of the individual mandate, and we also worry about the erosion of the gains in access as costs go up, we're not going to be able to afford to subsidize so many or to maintain the benefit packages or people will be cut from the rolls. Just look what's happening with dental care whenever we have a budget crisis, so, access will be eroded if we don't get health care under control and John Kingsdale is constantly reminding us of that.

And finally, for these reasons, GBIO believes that the administration and the legislature must act and act immediately to reign in these costs.

We advocate a comprehensive approach focused not just on providers which seems to be where the current conversation in the political arena has been focused but also on insurers, administrators and pharmaceutical suppliers.

At this time we'd offer four specific recommendations, hold insurers accountable to reasonable premium increases, specifically we support Governor Patrick's attempts to hold insurance premium increases to one and a half times for medical inflation rates for the upcoming year.

No. 2, reform the way providers are paid such that docs and hospital's recruits are incentivized to provide high quality care but neither too much nor too little based on patient needs. Specifically, we support an all care reform as recommended by the Special Commissioner and we support the payment reform ten patient priorities promoted by Health Care for All and Massachusetts Campaign for Better Care.

No. 3, like Health Care for All's testimony, like my friend Nancy's testimony, we believe that public health and prevention will have cost savings as well as improve the health and quality of life. I don't need to say more than that, public health is public health is public health.

Finally, we believe that consumers are the heart of the care system and must have a strong voice in the governing of containment reform spending. Consumers should be represented on any governmental entity as well as the governing of any ACO's or any payment intermediaries.

I want to thank Commissioner Auerbach for sharing this panel, Commissioner Morales for organizing it and doing so in such a thoughtful way that consumers didn't have to stand in line all day to testify, so, appreciation is there, thank you.

MR. AUERBACH: Thank you, Cheri, and our final speaker on the panel will be Rob Restuccia, Rob is the executive director of Community Catalyst, Rob.

MR. RESTUCCIA: I want to thank Commissioner Auerbach, Morales, Murphy and Attorney General Coakley for this panel.

Nancy referred to my gray hair, I'm perhaps one of the few people here who can recite all of the hospital reimbursement laws from 1980 to now starting with Chapter 372 in 1982.

I think it's important to note that Chapter 372 was legislation that was formulated by a group of business leaders that came together in 1980 concerned about hospital costs and they held private meetings at the business roundtable, they developed legislation and brought it to the legislature and passed the legislature without debate and without dissent and there was no consumer representation.

So, the change today is actually fairly dramatic that there is a consumer voice organized in this way and I think it's particularly complimentary to the state and to the commissioners and to the Attorney General and Governor to hold this meeting.

I'm executive director of Community Catalyst, a national nonprofit organization working to ensure that consumers have a strong voice in reforming the health care system.

Community Catalyst works in forty-one different states and working together with those organizations we also run campaigns to address some of the serious problems in the health care system.

Some of you may be familiar with the Prescription Project which we partnered with Health Care for All that addresses the issues of drug company abuses to prescribers and with Health Care for All partnering resulted in the successful passage of Chapter 305 and we are very thankful to the Commissioner of Public Health and his department in order to move forward on that.

This year we're partnering again with Health Care for All to address another serious issue in the health care system, the failure to provide high quality coordinated care to our most vulnerable populations. Nationally people with multiple health problems make the heaviest use of the system at the highest cost but with the poorest outcomes.

On the average the older adult with multiple chronic conditions makes thirty-seven visits to fourteen different doctors who prescribe fifty different separate prescriptions in one year.

Many of these patients are hospitalized for conditions that could be prevented, they're discharged from the hospital without adequate planning and then readmitted often within a month.

So, under the current system there are few incentives to address these problems, so, providers are often challenged to coordinate the care for the sickest patients.

Along with our national partners Community Catalyst is working at a state and federal level to develop and implement new payment and system models. We believe that realigning the payment system can lead to improved quality, lower cost and provide appropriate structures that are in place.

They include standards for care coordination, provider access, accountability, transparency and consumer involvement in the development of care plans and Community Catalyst is working in six different states on a campaign including Massachusetts to promote state action.

There's a lot of work that needs to be done here. In Massachusetts while the health care system ranks high on many measures, according to the 2009 Commonwealth Fund score card for health care performance, Massachusetts has the third highest reimbursement for Medicare enrollee of any patient of any state.

Despite this enormous expenditure Massachusetts ranks thirty-ninth in percentage of admissions for ambulatory care sensitive conditions, and thirty-seventh in percentage of thirty-day hospital readmissions.

In prevention Massachusetts ranks slightly higher but is still lower on many measures. While state action is important it's clear it's not sufficient. Federal action on payment and delivery reform is critical to making the whole system responsive to the needs of consumers.

The health care reform legislation now pending in Congress contains a number of important provisions that will make the job here in Massachusetts much easier including creating a center for Medicare and Medicaid innovation, strengthening the integration of Medicare and Medicaid through the creation of federal coordination care office, experimenting with payment reforms that move us away from a fee for service model starting with Medicare and pilot projects around accountable care organizations.

We are optimistic about national health reform and I think the next few days will tell us where we're going on that but we recognize in Massachusetts more needs to be done.

Massachusetts has been sort of a leader in so many issues around health reform, we have never addressed the issue of cost containment effectively. I think as the previous speakers have said, unless we deal with the issues of cost and quality, our access to reform is going to be threatened, thank you.

MR. AUERBACH: Thanks to each of you for terrific presentations and you've heard with earlier speakers and you've heard with other panelists a lot of speculation about what can motivate consumers and patients and how can they be drawn into this debate about what kind of an impact cost has on care.

Maybe I'd like to start by asking you your organization's experience with some of the notions of cost sharing or increase in cost sharing.

We've seen from some of the Division reports there is a trend upward in terms of cost sharing among consumers or patients, either through premiums, deductibles or larger percentages of their premiums or copays or deductibles.

I know that you all, and you have mentioned already some of what you have seen, so, maybe the question I would start by saying is are there particular subpopulations that you're working with where you're seeing there's unusual vulnerability or consequences of an increase in terms of cost sharing for consumers or patients?

MS. BANDA: Commissioner, for the older population there's been a lot of research that shows that if you increase cost sharing especially as to copays and deductibles, people stop taking their medications and when people stop taking their medications, especially people with chronic conditions, they just get sick again, they get sick again, they need to access more expensive care.

So, increasing cost sharing in our opinion especially on low income populations and from our perspective older populations is just economically very short cited and is going to put us all deeper in the hole than we already are.

MR. AUERBACH: Okay.

MS. SLEMMER: We've seen similar trends, we hear from people on our help line every day who are making just beyond 300 percent of the federal poverty level and when you shift additional cost to them it really prices care beyond their reach and then we're faced with these horrible anecdotes about people who now need access to the system but can't afford it.

So, we see it as short cited and really a bad trend for consumers and then we make referrals to HLA because medical debt goes and makes, people make choices that we would not want them to make.

MR. AUERBACH: Matt, would you say you're seeing its disproportionate effect?

MR. SELIG: Well, I would say that it is important to keep your eye on one area and that's, there's cost sharing in that people sign up for a health plan, they know what the copay is, they know what the deductible is, they know what the coinsurance is, but even after that there is, there's still cost sharing, additional cost sharing that's added and the types of things that we see are people who enrolled in health plans and their providers will try to get prior authorization, you know, particularly for situations like mental health care, and people will have that their providers ask their insurers for mental health care, and in many cases the authorization for payment process is just so overbearing that really payment is not available and it ends up being, you know, additional forced cost sharing for the consumer or sometimes the provider who will just eat the cost, so, we see that a lot.

And so, I think it's very important to keep in mind that there really is much more cost sharing to be seen out there besides what you might see in any particular health plan that somebody signs up for, but there's all sorts of other costs and an example for that that I just gave you is people with mental illness in particular increasing health coverage for particular services but the coverage really isn't there, and even though it is maybe in their health plan but in fact it is not accessible.

MR. AUERBACH: Thanks.

MS. TURNBULL: You're not going to let me answer this one?

MR. AUERBACH: Please do, any one you want to answer you can.

MS. TURNBULL: No, I just want to see if I can just make a couple of points about this one, consumer cost sharing is generally structured at the moment as quite regressive and hits lower income people.

I always say I'll take it more seriously when a CEO of some company proposes that they have a 2 million dollar deductible to make them more cost conscious.

I think we also have to I think think about where cost sharing can and can't be an appropriate incentive for people to change their behavior, so, we have seen some examples, for example, tiered drug copayments where it's been quite effective and that's because we actually have what economists would call perfectly substitutable goods, but for lots of things and particularly things that are particularly expensive I think there are two areas, one is one can imagine, you know, being taken in an ambulance for some care you needed in an emergency, and I guess now we could pull out the AGO report and see which hospital might be more cost effective but that's just not really very reasonable, and we also know that we have dominant provider systems in many parts of the state and I think several of the research reports that people have talked about today are that.

So, and the last point I'd make is U.S. consumers actually already pay much more out of pocket than consumers in any other country for their health care, so, you'd expect we might already be more cost conscious than other people, so, I think it suggests there are other strategies that we probably need to pursue.

MR. RESTUCCIA: I think to focus particularly on those with chronic diseases, the average person with multiple chronic diseases gets fifty prescriptions a year, one of the areas we're looking at and we need to look at the behavior of insurance companies as part of this is with asthma medications, for example, because we know that the inhalers now are propelled by new propellents, so, it's all brand name.

So, folks who have asthma are paying oftentimes $40 for an inhaler which they need once a month and if you think about a family with a couple of kids with asthma what the cost of that is.

You wonder in terms of the downside in terms of the hospitalizations that result from the failure of filling those or affording those prescriptions, so, I think in particular when you start thinking about folks with chronic diseases, you really need to think twice about how copayments and deductibles impact.

MS. SLEMMER: Can I just quickly say?

MR. AUERBACH: Oh, sure.

MS. SLEMMER: Health Care for All, one of the things that we see some opportunity in health care reform is the flip side of additional copays and that would be to drop copays for preventive care because we know that it's cost effective and will drive people to change behavior.

MS. TURNBULL: Right, in fact, we know that that's what some more forward looking employers are doing now.

MR. AUERBACH: Why don't you clarify, examples of preventive care that you would include in that category.

MS. BANDA: Screenings.

MR. AUERBACH: So, screenings, testing, screening for cancer, high blood pressure, diabetes, those type things.

MS. TURNBULL: Oh, sure, waiving copayments for the types of drugs that Rob was talking about, the people with chronic illness, asthma, diabetes where we know that actually compliance makes a huge difference in terms of preventing more expensive care.

MR. AUERBACH: So, let's talk about some of the other strategies that might work. You know, we heard from the AGO report that there is a growing, there seems to be an increase in terms of the utilization of more expensive hospitals, particularly hospitals versus lower cost hospitals even though the quality didn't seem to be correlated with quality, what did you make of that?

How do you think about that in terms, do you think about that, for example, from both the perspective of how patients or consumers are making decisions about which hospitals to go to and do you think that we could recommend approaches that might discourage the use of higher cost institutions where a lower cost institution was in the same general area, neighborhood, thoughts about that particular approach, Nancy.

MS. TURNBULL: All right, some approaches I think would be more supportable to me than others, you know, a couple of the ones people are talking about at the moment are tiered copayments, pay a higher copayment if you go to a more expensive hospital and again, I think particularly in certain parts of the state where you don't have any choice of hospital, that's not a very appropriate strategy.

An approach which I've always liked better and which was attempted here about ten years ago but met with I think some of the resistance of some of the provider forces that we talked about earlier, was a model that was born in Minnesota, it was called Patient Choice, and there consumers were given a choice at the point at which they made a decision about what health plan they were joining, they had to pick a delivery system, the delivery systems were tiered on price and on quality.

And so, the incentive that you faced was you paid more if you picked a more expensive delivery system and that always seemed to me a more appropriate way to me because it let people pick at the time that they picked their insurance but not at the time when they needed a particular test or medical procedure, so, I like that approach very much and would recommend that for people to think about.

MR. RESTUCCIA: And I guess from my perspective it's hard to know whether the genie's out of the bottle but we've encouraged and created a competitive health care system in which we instead of creating a system, a system that has a head, we have the competition.

And so, we're seeing institutions moving in the direction of creating profitable services and then advertising them heavily and then complaining that consumers are responding to that and we've created the incentives to do that, you know, it is, we have our priorities backwards.

I think of a system that was developed around neonatal intensive care that DPH developed twenty-five years ago, there's level 1, 2 and 3 and there's a system setup, why can't we do that in general and create some sort of rational system with allocation of resources.

We've allowed the determination of need really to become much easier to get, and you know, it's driven more by politics than by a rational system consideration.

So, to some extent I think we just need

to go back and have a system with a head that has some planning in it and stop the competitive environment that we've had for, you know, the past now, what is it, Nancy.

MS. TURNBULL: Too long.

MR. RESTUCCIA: 1991 maybe before.

MS. TURNBULL: No, I think that's right, I think this culture of sort of blaming the consumer as if we're choosing to go to these very expensive places, it does have it backwards and I think the important public policy question for state officials and legislators is do we believe that now that we understand more about the system, can it be recalibrated through private negotiations between payers and providers or do we in fact need to have, as Rob is suggesting which I agree with personally, more of a head to the system because I don't think given what the configuration of the delivery system looks like in parts of the state that a recalibration is possible, that that's significant reengagement by government.

MR. AUERBACH: Just so I think I hear you, you're both saying that part of the reason that patients or consumers may be choosing those facilities that are higher costs is because of advertising, promotion of the facility through marketing, that's, you think that's a significant factor in terms of that?

MS. TURNBULL: Well, I think that, yes, I do think that's a factor and in fact I think we need to interject in here the important role that physicians play in determining where we go to the hospital and determining what the growth in the number of physicians who are affiliated with particular systems, the power that that has given to those systems, the market leverage that the AGO report and others show, so, I think that's an important factor.

MR. AUERBACH: Cheri.

MS. ANDES: Yeah, I think that a lot of times in the political debate, you know, we get caught, we get caught thinking that providers only care about pay and that consumers only care about choice and the political access kind of goes in and around those two assumptions, and I think that consumers do care about choice but they also care about quality and they also care about cost and I think we're getting to a place now with the availability, you know, with the information that the AG's providing, with the availability of more transparency and the ability to objectively compare institutions that I think we can see over the next ten years a pretty radical shift in consumer behavior that's more rationally driven if we give consumers the tools that they need, and I think Nancy's suggestion about upfront having folks choose whether they're called limited networks, or you know, particular networks, tied to their ability to research those networks and tied to their ability to cost out those networks is a fabulous idea.

MR. AUERBACH: So, just to stick on that topic for a second, the topic of transparency, I think a lot of you have spoken to the importance of transparency about costs and quality with regard to a wide variety of different health care institutions, I think it's my impression the jury's out about how, how even accessible information is used and often people don't have the ability to access that information easily or weigh the different findings, what is your sense about how, what can be done in order to make transparency really a major driver in terms of some of the decision making that patients and consumers are making with regard to where so that we think about quality as well as cost.

You started to speak about that, Cheri, I don't know if you have additional thoughts.

MR. SELIG: I mean I would just say, you know, anecdotally when I think about the clients that come to our office, when they talk about where they're going to seek their health care, they're talking about where they can go, where there's transportation provided, a lot of them don't have cars, they may not have facilities in their area.

So, that's, you know, going to be probably at the top of their list in where they're going to go for care and they also want providers who know about their health issues, people who have chronic conditions especially they want to know their health background, and you know, many people are flexible but I would think that they're going to want to stick with providers they can get to and providers who know about their health situation and can provide the care that they need.

MR. AUERBACH: Yes, Deborah Banda.

MS. BANDA: Yes, thank you, I think we've made a lot of progress in the state on providing some of the tools that are designed to help consumers better navigate the health care system and to make educated choices, that said, from our perspective a lot of those tools are still pretty much designed for a medical audience and not for the consumer audience and they still have a long way to go for them to be truly useful for the average consumer, you know, not the person whose got a PhD in public health or whose grandfather was a doctor or whatever, but just the average caring person who wants to go and figure out how to get the best health care for the best cost for their family.

And again, I know there's a lot of effort made and there has been progress, but from what we've seen those sites aren't really designed for consumers even though they say they are.

MR. O'BRIEN: And just to follow-up on that and I'll try to not work in Chicken Little and Pac Man.

MS. TURNBULL: Go for another children's book.

MR. O'BRIEN: Nancy mentioned social determinants of health and education being the first one mentioned, I think you're talking about the same thing and how do we weave into the health care system, the employer based health care system education and approach that addresses those other social determinants of health.

We've heard from EMC, it isn't just one approach of health medical management but some of these other pieces and I want to get a sense from you how do we get consumers engaged.

MS. SLEMMER: I think that's critically important and I would invite us to think in addition to educational, it's also cultural confidence.

I think making sure that we have the information available and accessible for anyone who is trying to be able to make informed decisions is critically important as the foundation for consumer engagement, and as I say, we feel strongly that if you have an informed consumer, I thought that EMC story was very interesting because she has correlated these investments in lower health care costs and better health outcomes.

So, you know, at Health Care for All we struggle with that, one of the things that we've talked about is moving towards, looking to incentivize shared decision making so that the patient again is really at the center of the serious decisions they have made and has an opportunity to make choices that will better reflect what their values and expectations are.

And I think it's important in a variety of settings, I think because you're talking about chronic disease management, it's pivotally important and again, offers some real opportunities for savings.

MR. AUERBACH: Yes.

MS. TURNBULL: I guess I would say a couple of things, you know, I think the issue is what do we want consumers to be engaged to do and to me EMC's program, I liked it very much, since I know about it because it seems as if it tries to engage people to engage in healthier behaviors and to give them tools that are not punitive but that are encouraging to be able to do that.

So, I think that's an important role which employer programs can play. I think where we get into difficult grounds is how can we appropriately use price sensitivity as a tool for changing consumer behavior and to me the tensions there are do we try to make consumers price sensitive at the point at which they go to get medical care, a particular service which are often very vulnerable, anxiety produced at times or sometimes they don't have a choice of provider and it's difficult to make good decisions of anyone whose been in that situation should know or do we try to make them price sensitive by getting them to pick and agree to get their care from a delivery, an organized delivery system that is good value and produces high quality and give them the information to let them make discernments among systems on those credentials and not just every time they go to get care and I think many people think that what could be exciting out of payment reform and what could be exciting out of our increased ability to actually give consumers better and better quality information is that we could structure a system in which consumers can appropriately make those types of decisions, you know, not to say if you go to this hospital, you have a $500 deductible and this one you have 200, because at the end of the day the deductibles can really make most people price sensitive given how much the hospital admission costs and wouldn't be things that I don't think any of us would want.

MR. AUERBACH: So, let me ask a related question, one that was raised and that came from one of the audience, and that is the use of community health workers as part of the clinical team and maybe being reimbursed for their activities, community health workers being not licensed health care professionals at this point, maybe down the road but more community members who may be from the same racial, ethnic, linguistic group of the patient population, thoughts about that, the use of those workers and whether or not those services should be thought of as something to pay for maybe under global payment, global reimbursement, Rob?

MR. RESTUCCIA: I think the answer is yes, I think part of the cost quality equation here is to really change the workforce of a new delivery system and community health workers are an integral part of that.

I'm on the board, Nancy and I are on the board of Commonwealth Care Alliance which is working to care for the disabled population in Cambridge and they've just hired community health workers as an integral part of their delivery system and the idea is you're going to keep people out of the hospital as much as possible as a result saving money.

I think that community health workers in so many ways have demonstrated their effectiveness not just Massachusetts but across the country and across the world, you know, the fact that we don't really recognize them as a profession and an integral part, I think it's important to think about the training and integrating them into the delivery system. How can you have care coordination without it.

I think actually in Springfield it's like one of the key places in the country where community health workers has been demonstrated to be a really effective model and the health centers and hospitals have all worked really collaboratively to make that work. Thinking about how to integrate that into the system, reimbursement I think is incumbent on us moving forward.

MS. TURNBULL: Yeah, that's the exciting thing about global payment, dare I use the word capitated systems, it unleashes the creativity of providers to think about what are better and cheaper and higher quality ways to do those.

MR. AUERBACH: Let me ask the flip side of that just for a second because we have a little bit of time, you heard a number of people say well, maybe a way to effect cost or reduce cost is to have some sort of added cost to health care premiums, if you're a smoker or if you're overweight and that would create, you know, the motivation for patients and consumers to take more control of their health and they would be healthier people, and therefore, the cost would go down, reaction to those proposals.

MS. ANDES: Well, I mean my gut reaction is it's incredibly regressive way of coming at funding our health care system. We already do it to a certain degree with the regressive taxes, the tobacco tax which we actually support, and you know, various other sin taxes, alcohol tax, but it seems to me that to fundamentally punish people for being ill, to punish people for an addiction, to punish people for, you know, obesity is, just strikes me as fundamentally wrong.

MR. AUERBACH: Other thoughts?

MS. BANDA: Amy and I indicated earlier there's been some evidence that shows if you actually do reduce the cost sharing on those populations, it promotes people to more closely follow the doctor's orders and that leads to better health, so, you know, punishing I guess is a moral issue here too but punishing folks with medical.

MS. TURNBULL: I mean I think on moral grounds and I agree with those comments, I don't think there's any evidence those are effective strategies in terms of preventing, in getting people to stop smoking, or you know, with it Harvard could just charge me more on my health insurance but I don't think there's any evidence that those actually work.

MR. AUERBACH: So, maybe there's just a final question then is what would work, what would work as a way of, particularly on that issue of encouraging healthier behaviors, are there things that can be built into the system of reimbursement that would in fact encourage, you know, people to give up smoking, people to eat healthier foods, to, you know, improve some of their behaviors so that their risks would be less.

MS. TURNBULL: Well, I think on the smoking front, and you know, you and your colleagues at the DPH have documented this well, we know that the inclusion in health insurance benefits of robust smoking cessation programs and smoking cessation drugs and a variety of other interventions actually are proven strategies, so, those are ones.

MR. AUERBACH: As covered benefits, you're saying as covered benefits.

MS. TURNBULL: As covered benefits, you know, I don't know of an intervention that's been proven to be effective as an add on to health insurance benefits, that's a good strategy on obesity, I mean I think that's a very multifactoral program which needs this whole system wide approach in health insurance to really be an important component of that, I have not seen any evidence on it.

MR. AUERBACH: Thanks.

MS. ANDES: And I would just support, you know, going back to the idea of community health workers, going back to an idea that I think used to be more popular than it is now which is school based health clinics, going back to an idea of what the faith community talks about parish nurses which has been a very popular and very successful model inside congregations for starting walking clubs and for managing hypertension and some of those things that don't need high level care, don't need even a doctor's visit.

So, rethinking how some of those things can be delivered close to home where other behaviors can be influenced and changed.

MS. TURNBULL: Perhaps on some of those things we could fund it, you know, I mean not directly through health insurance premiums but in partnership with some of the organizations like health insurance that would benefit from the strategies which are more successful.

MR. AUERBACH: Any closing comments anyone would like to make on a topic we haven't touched on?

MS. SLEMMER: Well, there's an awful lot of commentation going on currently about how Chapter 58 has affected the state and our state finances and we feel strongly that this is, we have not bankrupted the state, we have made this investment and have benefited tremendously from bringing 400,000 people into our health care system and now it's really time to take the next step of making sure that the care people are accessing is both comprehensive, cost effective and of the highest quality possible and we're very optimistic that we'll be able to do that in the next phase of health reform in Massachusetts.

MR. AUERBACH: Cheri.

MS. ANDES: I'll add one piece which is that, you know, I said in my testimony that we support the recommendations of the Special Commission, we were disheartened that the Special

Commission didn't include the consumers on its make up and I think that, you know, part of the success of Chapter 58 and putting together a broad based coalition across the Commonwealth that could support not just health reform but the complicated implications of health reform which required enormous political consensus had everything to do with having groups like this at the table and we think that the question of payment reform and cost, bending the cost trends is equally important, equally complex and will require an equal effort on the part of consumers and inclusion on the part of consumers and advocates to make a difference in that arena.

MR. RESTUCCIA: And just a final pitch, national reform hangs in the balance, it's going to happen in the next few days or not, I wouldn't make any assumptions about whether it's going to pass or not or how your representative is going to be voting.

So, if you are concerned about cost issues and you don't want Massachusetts to be alone in this, there are opportunities to call your legislature.

MR. AUERBACH: Well, thanks to each of you, these are great topics, I think clearly you've illustrated the importance of having a consumer voice at the table and many of these topics I think we'll be continuing to talk about in the coming months, so, please join me in thanking all the members of the panel.

(The audience applauded.)

MR. MORALES: Thank you, Commissioner Auerbach and to the distinguished panel, I thank you as well and I want to conclude today's hearing but I just I jotted down notes throughout the day and I just want to include by just sort of recapping some of the day's highlights but prior to doing that I want to thank Attorney General O'Brien, Lois, their team, Commissioner Murphy, our panelists and especially my team who is here today who has worked really hard and some of our expert researchers, but I also want to thank you who have sat here patiently and willing to listen to today's testimony and discussion.

It's certainly a complex dilemma and one that requires immediate attention, so, just to sort of offer my thoughts, things that I've sort of jotted down throughout the day as I've been listening, first and foremost, I'm very encouraged because Governor Patrick, Senate President Murray and other state officials reminded us of the extraordinary leadership and commitment that we have from the administration, legislature to tackle this difficult challenge and identify strategies that will both provide immediate relief to the residents and businesses but also to develop actions for lasting meaningful change in the Commonwealth's health care system.

No. 2, the Division's experts summarized some of the key findings from our analysis, for example, between 2006 and 2008 private spending per member for health care in Massachusetts grew by about 15 percent, more than 75 percent of the growth occurred in outpatient hospital facilities and physician and professional services and care is being provided at more expensive settings over time.

Interestingly enough, price, not utilization virtually, is the single most important factor fueling rising health care spending. No. 3, the findings from the Division of Insurance and the Office of the Attorney General echoed some of the agency's findings, for example, one area of particular concern and opportunity is the wide variation in prices paid by private health plan for the same service by different providers, and in addition, the AG succinctly showed that prices are correlated to the market leverage and may not be correlated to quality.

Also, Len Nichols reminded us of the dire impact that rising health care costs will have on our state and local economies if nothing is done to mitigate health care cost growth immediately.

In the afternoon we heard from employers of varying sizes about the impact of rising health care costs have had on their ability to do business, to hire workers and grow.

Our analysis highlighted the disparities in the insurance market between different sized employers and panelist testimony only further conveyed that point.

We also heard from consumer groups about the impact of costs on access to health care, the need for better coordination of care and the burden of rising premiums on individual and family budgets during this economic time.

We also heard about the need to create incentives for consumers and how and where they access care and prioritize prevention and wellness. Panelists also reminded us of the benefits of prevention and about the value of health care reform and insuring accident coverage and urge us to address costs with the same sense of urgency.

The goal of today was to help set the stage for conversations on Thursday and Friday that are more specific to the health care system, what we're doing about cost and to develop long term policy solutions, which by law the Division is required to issue weeks after these hearings.

And so, we're going to continue this dialog Thursday and Friday, we'll reconvene this Thursday at 9 a.m., thanks again everybody.

(The audience applauded.)

(Whereupon, the hearing adjourned at 3:50 p.m.)

C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS
SUFFOLK, SS.

I, Julie A. Healey, Certified Shorthand Reporter, Registered Professional Reporter, and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify:

That the testimony that is hereinbefore set forth is a true and accurate record of my stenotype notes taken in the foregoing matter, to the best of my knowledge, skill and ability.

IN WITNESS WHEREOF, I have hereunto set my hand and Notarial Seal this 9th day of April, 2010.

Julie A. Healey
CSR, RPR
Notary Public

My Commission Expires: March 10, 2017

Massachusetts Health Care Cost Trends Final Report

Appendix C.5c

Health Care Cost Trends Public Hearings

Transcript for Morning Session Thursday, March 18, 2010

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COMMONWEALTH OF MASSACHUSETTS

Executive Office of Health and Human Services
Division of Health Care Finance and Policy

PUBLIC HEARING RE:

HEALTH CARE PROVIDER AND PAYER COSTS TRENDS

BEFORE: David Morales, Commissioner

Held at:

University of Massachusetts Boston
Joseph P. Healey Library
100 Morrissey Boulevard
Boston, Massachusetts 02125

Thursday, March 18, 2010
9:07 a.m.

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I N D E X

PROCEEDINGS

COMMISSIONER MORALES: Good morning. My name is David Morales. I am the Commissioner of the Division of Health Care Finance and Policy.

I am joined by a key partner here, Assistant Attorney General Lois Johnson. I will be joined later today by Commissioner Joe Murphy of the Division of Insurance.

Welcome, and thank you, again, for joining us today.

Today marks the second day of the Division's public hearings on Health Care Cost Trends.

For those of you that were not in attendance on Tuesday, I will take a few minutes to provide an overview of our goals for the hearings and to explain the general format.

As many of you know, Chapter 305 of the Acts of 2008 directed the Division to issue reports on health care costs and to then hold public hearings with key stakeholders from the health care system to help determine the best course forward with action-oriented solutions.

These hearings are the culmination of over a year's work of research in health care cost growth in Massachusetts by the Division of Health Care Finance and Policy, the Office of the Attorney General, the Division of Insurance and many others like you.

Our collective efforts point to a sense of urgent action on costs as well as the obvious.

For example, we know Massachusetts' health care system is a critical component of the state's economy. Health care is the state's top industry, the largest employer of Massachusetts residents and accounts for over 13 percent of its 365 billion dollar gross state product.

The Commonwealth Fund ranks Massachusetts 7th overall among states on its states score card system which measures health performance system. This success can be partly a attributed to a commitment to an increase in enrollment in coverage as well as supporting access to care for residents without insurance.

Moreover, Massachusetts is fortunate to have a strong provider network which includes some of the best hospital quality indicators and health insurers that are consistently rated among the top 10 best hospitals and plans in each category nationwide.

At the same time we know urgent action is essential. Massachusetts is grappling with escalating health care costs which are consuming a greater portion of the economy and impacting wage growth.

On Tuesday we heard from experts about key challenges faced by the Massachusetts health care system -- price variation, lack of coordination of care and disparities in the insurance market between different size employers. We heard about the impact that rising costs will have on our state and local economies if nothing is done to mitigate the trend we are experiencing both here and nationally.

We heard from employers of varying sizes about the impact that rising health care costs have had on their ability to do business here and to hiring workers and to grow.

We heard from consumers about the impact of cost on access to health care, the need for better coordination of care and the stark urgency of addressing this issue now.

Today we will examine the factors that contribute to high health care costs in Massachusetts including the structure of the health care system and the payment methods currently used by our insurers.

Understanding these factors will better prepare the Commonwealth to evaluate and develop strategies that have the potential to simultaneously mitigate cost growth and improve quality.

Before we begin, I want to quickly review today's agenda. We will start with a presentation on creating the frame work for high performing organizations by Doctor Stephen Schoenbaum, the Director of the Commission on High Performance Health Systems at the Commonwealth Fund.

Next we will have a panel of witnesses to discuss the Massachusetts health care delivery system moderated by Michael Bailit.

We will then break for a short 30 minute lunch. The cafeteria is located on the first floor.

We will promptly begin at 1:00 p.m. with a presentation by Paul Ginsburg, President of the Center for Studying Health System Change on pricing of services in the health care market.

Lastly, we will have a panel of witnesses discuss cost drivers moderated by Nancy Turnbull.

I want you all to know that panelists will be sworn in and will, therefore, provide their testimony under oath.

While the moderator will ask the

majority of questions, we may intervene at the head panel at any point today.

As was the case Tuesday, I also want to encourage you all in attendance to engage in today's discussion. Members of my team will pass out index cards and they are also available at the registration table should you need them. Please write any questions that you may have for the panelists and give them to members of my team.

At the end of each panel, the moderator will select certain questions and ask them.

At this time I would like to ask Doctor Stephen Schoenbaum with the Commonwealth Fund to speak, but first Stan Wallack.

PROFESSOR STANLEY WALLACK: Let me just add to Commissioner's Morales' comments about the work that the Commonwealth Fund is doing on high performing organizations and high performing health care.

This is to me in any way one of the most exiting things that is going on in the foundation world with regards to a project. It has really been -- it is cutting a new path and new things and every year those of us in academia or those of you who do research get a note from the Commonwealth Fund on how do you rate the Commonwealth Fund -- and I probably shouldn't tell you but -- and I do the checklist.

I go through the list when I do the checklist and I rank the Commonwealth Fund right at the very top and the reason I do is because of what is going on with what you are doing, Steve.

So I think it is great that you are here and I appreciate that you have come today.

DOCTOR STEPHEN SCHOENBAUM: Thanks very much. It is very much like coming home since I grew up here and was here until 10 years ago.

Thank you, Commissioner Morales for this opportunity to participate in this hearing and I just should mention that the Commonwealth Fund is a grant-making foundation it has been in existence since 1918 and it has national scope but it is based in New York City.

In 2005 the Fund's Board of Directors approved our developing a commission on high performance health system and charging it with recommending policies and practices that will move the United States towards a higher performing health care system that achieves better access and improved quality, greater efficiency and focuses particularly on the most vulnerable due to income, minority status, health or age. There are currently 17 members of the Commission. The Chairman since its inception is James Mongan who is former Chief Executive Officer of Partners Health Care here in Boston. There are two other current members of the Commission from Massachusetts, Maureen Bisognano, the Chief Operating Officer of the Institute for Healthcare Improvement and Michael Chernew, Professor of Health Economics at Harvard Medical School.

For the first four years, Cleve Killingsworth who then was Chairman and CEO of Mass Blue Cross/Blue Shield was also the Commissioner.

Early on, the Commission established that the objective of health care in a high performance health system is to help everyone to the extent possible lead long, healthy and productive lives.

It stated that a high performance health system does this by providing access to care for all, high quality health care, efficient use of resources and relentless system and workforce innovation and improvement.

The Commission evaluated the performance of the U.S. through national and state score cards and the score cards document that in each division -- in each dimension of care, the average performance across the United States is only about two-thirds of achievable bench marks. The bench marks that we use on the score card are almost without exception based on achieved performance, not on ideal performance that one might say was the theoretical level and this just illustrates some of those dimensions and the fact that the results have been fairly similar in two separate measurements across the country.

There is also wide variation across the country which you can imagine given, knowing that the bench marks are about 30 percent higher than the average performance. And this diagram which you probably can't read but in fact all of these are available on our website shows the point that Commissioner Morales made which is that Massachusetts' performance was very high. It was 7th out of the 50 states and the District of Columbia.

Like almost all of the states, however, Massachusetts' performance did vary by dimension.

Now not surprisingly given the Commonwealth's landmark health care reform law and its implementation, Massachusetts ranked first in the country on access to care.

It was fifth on prevention and treatment, and sixth on healthy lives, and seventh on equity and 33rd on avoidable hospital use and costs.

Although it is fitting that the principal subject of these hearings is related to cost and cost is higher throughout the United states than it is in other countries, so it is an issue nationally.

Massachusetts does rank near the middle of states in per capita health standing as a percentage of gross state product and better than average in employer premiums as a percentage of median household incomes for persons under age 65.

In November of 2007 as the country was beginning to prepare for the last presidential election about two years after the Commission was formed, it published a report that laid out a "ambitious" agenda for the next President. It defined a set of five key strategies for achieving a high performance health system in the United States.

The first is to extend affordable health insurance to all. The second is to a line financial incentives to enhance value and achieve savings. And the third is to organize the health care system around the patient to ensure that care is accessible and coordinated. The fourth is to reach current bench marks, remember that the country is only performing about two-thirds, and then continually raise performance for high quality efficient care.

In short, that could be translated as increasing accountability should be ensured for quality and cost and the fifth is to develop accountable leadership and strong public private collaborations throughout the health system.

Now in Massachusetts you have extended health insurance and have the lowest rates of uninsured in the country.

But the challenge now is to make it sustainably affordable and I am almost certain that that will require attention to all of the other four strategies and because there they are interrelated, it will require addressing them together and not in isolation from each other.

I would love to be able at this point to give you a listing of high performance delivery system organizations in the United States and in Massachusetts -- ones that have demonstrated excellent access, high quality, equitable care that achieves excellent clinical and patient experience outcomes and has costs that are low in trending downwards year over year, but I don't have a list of organizations that meet all of those criteria. And the U.S. lacks an agreed upon set of performance criteria for health care organizations that can be used to assess even just quality and cost across all of the populations that they serve. And I emphasize across all of the populations. The measures we have cover just part of the picture.

For instance, last summer the Institute for Healthcare Improvement and the Brookings Institution convened representatives of 20 of the more than 300 hospital referal regions or HRRs from around the country. They chose 20 of the HRRs that have been shown by investigators at Dartmouth Medical School to have some of the lowest costs for comparable outcomes in the country.

The choice of those communities as exemplars of high performance however has since been criticized as representing examination of only limited outcomes and only Medicare data on costs.

Although that is undeniably important for Medicare and Medicare is the single largest payer for health care in the United States, and it needs to know who performs best for its beneficiaries and how they do it, I believe and this is a personal belief that a major national and state priority should be obtaining an agreement on a standard set of quality and cost measures that can be collected across all populations and all payers.

There will be exemplars out there that will meet this criteria and we do need to find them and learn from them. And to develop so called accountable care organizations, and recognize their achievements it is going to be essential to reach general agreement on how their performance will be measured, essentially what they are going to be accountable for.

Although there is a lot that we don't know about performance, let me start with what we do now.

First, as is illustrated in the next two exhibits and I am told that these will be posted so I am not going to read them or dwell on them at this point, but as they show, we know that organization of care is a necessary condition for higher quality and cost performance. It is not a sufficient condition.

We also know that integration of

care within health care settings and across settings -- so across transitions in care is important for achieving higher quality and efficiency of care. And a key element for achieving integration and coordination is information continuity.

Now information continuity is the ability to provide a continuous flow of data and synthesized information across all of the people and units that are involved in a patient's care and it doesn't happen often.

The third thing we know is that our current lack of integration and organization of care reflects at least two things. The next two exhibits you will find which come from surveys that we do across countries, and these come from a survey of primary care physicians that was done almost exactly a year ago, show that there has been very slow adoption of health information technology in the United States. We and Canada are towards the bottom of the pack there among health information technology for primary care physicians and although Massachusetts does somewhat better than the rest of the country, and larger groups and there are several here tend to do better than smaller practices, we are still not approaching the kind of levels that you see out on the left-hand side of the slot.

And also some people or physicians in some other countries have much greater functionality than is used in this country but there we are not on the bottom of the pack -- we are about 4 in on the right-hand side.

This is beginning, by the way, to be addressed at the national level, in part thanks to the appointment of a strong National Coordinator for Health Information Technology, Doctor David Blumenthal who is from here and about 30 billion dollars of funds specifically for health information technology that are in the American Recovery and Reinvestment Act of 2009 also known as the Stimulus Bill.

Another key factor that fosters lack of organization and lack of integration of care is the current payment incentive structure for health care. It is predominantly fee for service which encourages higher volume of services and fragmentation.

And current payment incentives which also include DRGs don't foster care that meets the highest quality and safety standards. There is no financial incentives for hospitals to reduce emergency room visits, hospitalizations, complications such as central line associated bloodstream infections or re-hospitalizations.

Nonetheless, some hospitals aren't participating in efforts in each of these areas.

Indeed a group of hospitals in Massachusetts is participating in an effort to reduce re-hospitalization that we are funding and that the Institute for Healthcare Improvement is the grantee for, but many hospital C.E.O.'s are able to sleep comfortable at night without addressing these issues squarely and many feel there is no business case and that they can't afford to address them. It is not necessarily the truth that it has been shown in some settings but it does occur as a feeling.

The next exhibit shows the relationship between the two major types of payment reforms that are being talked about today and the organization of the delivery system.

Now the two major types of reforms, bundling and pay for performance have very different objectives.

The principal objective of bundling is to stimulate more efficient use of services; whereas the principal objective of pay for performance is to ensure better quality of care and achieve better outcomes.

Now there can be some mix of these two obviously but I am talking about the principal objectives and it suggests, by the way, that a payment system that wants to achieve both would probably have some blend of these mechanisms.

There is also a range in complexity

of each so bundling ranging in complexity from the simple use of DRGs by Medicare which aggregates the hospital services provided in the single admission to full global payment capitation which aggregates a payment for a single patient over a period of time such a year.

Pay for performance rates on payments based on simple process measures to more sophisticated measures of coordination and risk adjusted outcomes of care.

And there are also it turns out is a range in delivery system organization. If you think about it, it ranges from very small practices, solo, two'zies, three'zies, single hospitals, out into through various kinds of physician hospital organizations and physician organizations, multi-specialty group practices and then fully integrated physician hospital delivery systems.

It is much more feasible to achieve higher performance, i.e. more effective and more efficient care in the more organized forms of delivery system.

Although, as I mentioned earlier, the organization itself is not a sufficient condition to ensure that.

There are many ways that hospitals can or I should not say hospitals, there are many ways that organizations can achieve better health outcomes for their patients at lower costs and these are detailed actually in the report by someone who works with us Douglas McCarthy and there is a reference to it in the printed testimony and it its on our website.

The challenge is to drive health care delivery from its current mostly fragmented unwired state into the organizational structures that are at least capable of achieving the desired health and cost outcomes.

You are undoubtedly familiar with Mass Blue Cross/Blue Shield's alternative quality contract which is one model that one payer has adopted for encouraging organization and performance.

There are others. And others being

employed by Blue Cross/Blue Shield in Michigan and it is interesting because its physician group incentive program is a pay for performance program that rewards both quality and cost performance. It involves about 6,500 physicians in Michigan. The payments are made only to groups of physicians such as a physician organizations and electronic data collection and sharing is a requirement of participation.

In an effort to create program ownership, it is physicians who structure the initiatives for the insurers.

One concerning about stimulating the development of large health care delivery organizations is reflected in the recent preliminary report of Attorney General Coakley on health care cost trends and cost drivers in the state and a similar report from the Office of the Health Insurance Commissioner of Rhode Island.

And both of these reports provide evidence that market leverage is a dominant driver of current payment and that is an issue that needs to be dealt with and will require strong and talented leadership at all of the levels it is occurring, national state and local. It is going to involve addressing head on very complicated issues of health care design and financing.

Speaking personally, again, I believe that at a minimum we are going to have to achieve price and performance transparency and possibly we will need all payer prices or all payer rate setting.

Only two states, Maryland and West Virginia, currently have all payer hospital rate setting.

In the early 1990's, it was thought that managed care would be more effective at controlling hospital costs and health care spending than regulation. Yet during the period of 1975 to 1991 when Massachusetts had its program, the increase in hospital costs here averaged 20 percent below the U.S. as a whole and since discontinuing the program, Massachusetts increases in hospital costs have been slightly above the national average.

It is worth remembering that there are many ways to bend the cost curve. And we have but out a couple of reports. One was the original bending of the curve report back in December of 2007, and another was one path to a high performance U.S. health system in February of 2009 and both include modeling a variety of options for changing cost at a national level.

Now, what the point that I want to make with this slide is that the ways of bending the cost curve relate not just to payment reform and regulation but to diverse efforts such as generating better evidence and deploying it to achieve evidence-based medicine and informed decisions by patients and increased efforts to control obesity, tobacco and substance use, things that lead people to use health care services to a greater degree and incur costs.

To change the existing cost trends is going to require full court press and this simply doesn't occur without strong and competent leadership at the national and state levels. Government's levers should be exercised in the context of goals for performance of the health system and we currently have no national goals and I am unaware of explicit state goals.

In setting goals, it is highly unlikely that the state or the nation can fully satisfy all disparate interests within it and for the sake of discussion I am going to assume that one goal is going to be the bend the cost curve and one of the strategies will be to develop more robust primary care, which has been a sine qua non in almost every country that has better outcomes and lower costs than the United States does.

Yet, how will you do this in Massachusetts? The state has an excellent large highly specialized and sub specialized physician work force even though in primary care oriented health systems specialists and subspecialist are still essential to provision of excellent care, one needs relatively fewer of them than we have today in relation to the number of primary care physicians or primarily care practitioners. And another example of the strategy to bend the cost curve and provide higher quality of care would be to develop a group of locally organized after hours services across the state to reduce the use of emergency rooms and decrease hospital admissions.

The Netherlands and Denmark both have required and developed such programs. In both countries they are physician organized and have achieved excellent results.

Yet another state strategy might be to encourage substitution and competent but less expensive labor, for more expensive labor. This is likely to require a change in various state scope of practice laws and regulations. It is predictable that proposing such changes is going to pit various groups of professionals and workers against each other and the state. Physicians and nurses, subgroups of physicians and nurses -- subgroups of physicians such as ophthalmologists versus optometrists, nurses and nursing assistants.

So those are issues that will need to be dealt with if one chooses that approach in to trying to change the cost curve.

So in order to set goals and develop and implement strategies to achieve them it is going to be critically important for government to convene the key stakeholders whose participation is essential to achieving the goals, recognize that the various stakeholders do have conflicting interests and seek to come up with a fairest solutions consistent with the goals.

Finally, and certainly not least, it is extremely important to engage the public or patients. They must be convinced that whatever is done will yield as good or better care and more affordable care than they otherwise would have.

The national reform debate has

shown that this is an uphill battle. The public may be beginning to realize that the U.S. health system could perform better but most individuals who do have insurance coverage and access to health care, believe that there own care is at least satisfactory if not excellent and they fear change.

The major issue for individuals has been costs of care, bought contributions for coverage and out-of-pocket costs yet efforts to reduce health care costs are greeted suspiciously by the public and individuals as efforts to stint on needed health care services.

So the public must understand just what is being done and why and ideally the public should be integrally involved in the process as should all of the other key stakeholders.

The central principle of patient centered care "nothing about me without me" should also be a central principle of efforts to reform the health system and improve its performance.

Thank you.

(Applause from the Audience.)

PROFESSOR STANLEY WALLACK: As Commissioner Morales said we are going to take -- we really want questions from you who you sitting here with us. I think they were very helpful on Tuesday in sort of getting some issues addressed but what I plan to do -- whoever has the clicker -- we will maybe go back to figure, Exhibit 7. What I want to do is actually use that.

I want to try to structure the discussion with Steve is around sort of what this -- what I sort of consider the macro picture, kind of the major dimensions and then I am going to move down to those of us who worry about some of these microprocesses in organization and so I am going to talk about this framework and then I want to talk about how do we really get organizations to be paid patient centered and then I want to move on to, I think, the Commonwealth's work that Steve got into -- what kind of policies do we need to think of with anti-trust and with regards to other actions that the state needs to be involved.

This isn't going to happen simply by looking at the private sector all by itself.

So let me start off with the first one and Steve mentioned when he first introduced himself, he said he knows Massachusetts. I think he knows Massachusetts very well.

He spent at least 20 years here in the '80s and '90s, working with the Harvard system, Harvard Health Plan and he was in both in Massachusetts and Rhode Island and so what I would like to start off the question to Steve with given your knowledge and given your experience with high performance health systems is to let's start off around the team of organizations.

Give us the sense given that you know Massachusetts, how can we start to move from left to right -- what are the kinds of things that you think are most important that you recommend?

You can sit down.

DOCTOR STEPHEN SCHOENBAUM: Well, this is at a critical question and I don't have an easy answer to it.

Our Commission has been struggling with it, I would say now for about two years and clearly it has something to do with how do you offer incentives could be mostly positive, possibly some negative ones that make the status quo more uncomfortable but probably mostly positive ones that get small practices to aggregate and not aggregate solely for the purpose of negotiating higher prices with payers which happens if they are single specialty groups but rather in the multi-specialty groups.

How do you get them to then work on some combination of quality and cost management?

Well, the closest that anyone is coming to that is this idea of developing accountable care organizations and that is presumably a group of providers who take responsibility for quality and cost performance, and the models that I think still need to be worked out with and need to be worked out so that all of the parties feel like they are getting a reasonable deal.

And let me see if I can parse some of what I just said. It is likely and I will go back to some themes that I have already raised. It is likely that if one has an accountable care organization that is accountable for a population, it is going to need to be more primary care oriented.

I think the data is compelling. They have been put together by Barbara Starfield who is a professor at the Johns Hopkins Bloomberg School of Public Health and has worked in this area for years and they show that countries and parts of the United States that have more primary care services have better outcomes, lower costs and more equity of care.

There are a number of features that are related to that and there is some debate about what those features are and let's say which of those features has the dominant importance.

I think Barbara Starfield herself would say it is the comprehensiveness of the primary care practice. It is their ability to handle within the practice most of the problems that they see and not necessarily need to send people to a consultant for every single individual problem that they have. So that doesn't mean just having people who call themselves primary care physicians or primary care nurse practitioners but people who have skills in the whole variety of office forms, ambulatory forms of let's say dermatology, ophthalmology, ENT, mental and behavioral health. A lot of mental and behavioral health issues come up in a primary care practice and orthopedics, OB/GYN.

I mean there are all sorts of issues here that ideally would be handled in that practice.

As people have started thinking about how do you get that, they start talking about this thing that has lately been called medical homes. There are also people who don't like that term. But whatever you want to call it, it is really comprehensive patient-centered team-based primary care and to not somehow imbed that kind of structure into an accountable care organization, I think will doom it to failure in meeting certainly the cost goals and probably the quality as well, because Starfield has always showed both of those as a result of a more dominantly primary care oriented systems.

PROFESSOR STANLEY WALLACK: Okay, let me -- there are a number of questions from the audience already -- let me follow up on one.

The way you started with was the idea of small group practices maybe joining with others and starting to grow to become this more comprehensive service and you mentioned this model going on in Michigan, the physician group incentive program.

We had worked over the years with

Henry Ford in our physician group practice demonstration as a leadership organization, but is that statement -- would you just give me a few more comments about that model -- how comprehensive it is -- how physicians are actually -- how they desire to work -- are they looking to move into that program? Are they happy with that program?

DOCTOR STEPHEN SCHOENBAUM: The honest answer is we don't know yet and this limited amount of data that is available through things like the Michigan Blue Cross/Blue Shield website, however, we -- I believe the Commonwealth Fund's Board has yet to meet -- it meets in April but being proposed to it is an evaluation of that program and until we have that evaluation, it is really very hard to say.

If you ask me, it sounds like it is a very effective pay for performance program. It is interesting with the feature that I mentioned which is that it doesn't just address quality, it also addresses costs.

And I would assume that it is going to turn out to be working better than, let's say, the Integrated Healthcare Association in California which is trying to do this now for several years and has been evaluated by Meredith Rosenthal here at the Harvard School of Public Health and where, in fact, there seems to be relatively minimal effects in that instance of the pay for performance.

PROFESSOR STANLEY WALLACK: Here is a question from the group, how might ACOs help make sure the state health care system doesn't add too many duplicate high cost, high intensity settings?

How do ACOs get us to the right number of centers of excellence assuming we have this world of ACOs in the state?

DOCTOR STEPHEN SCHOENBAUM: Let me start from the other side which is suppose you are running a center of excellence and it is a little presumptuous of me to put myself in the place of some of the people that will be on the next panel, but, in fact, I think they have a choice if

-- let's assume there is a strong accountable health care organization that is developed, it is going to need highly specialized services. It is going to want those to be provided with ways that achieve the best outcomes at the lowest obtainable costs.

And so one role for places that are highly specialized in particular areas which is how I am interpreting the centers of excellence here is to be offering those services to one or more accountable care organizations.

A second potential role is for them to become accountable care organizations and be the organizer of the larger delivery system.

Either one of those is a stretch, but I think both are do'able and what I don't know is whether the proposals for what are the benefits of being an accountable care organization will be sufficient to be enticing to these institutions that are centers of excellence that are probably the most organized parts of the current health care system to then go in one or another of those directions.

PROFESSOR STANLEY WALLACK: It is certainly true of the state. Lois?

ASSISTANT ATTORNEY GENERAL LOIS JOHNSON: Just to follow up as you have noted there is a very real concern that the more we sort of move to the right and encourage integration and merging and creation of larger systems, not one'zies, two'zies or joining group practices -- it raises a concern of stimulating the kind of market leverage that the Attorney General's report documented -- how do we counteract that?

What kind of measures of efficiency or price can we use to benchmark these groups.

DOCTOR STEPHEN SCHOENBAUM: Well, I try to elude to a couple of those in the testimony.

I mean one possibility is that one does rate setting particularly when somebody is exhibiting market power because that is an approach to dealing with it.

There is a paper, I just got an e-mail earlier this morning before the session that is in Health Care published today showing that Medicare is not profitable for hospitals that have a lot of market leverage because they have high cost structures whereas it is profitable for the ones that don't have a lot of market leverage because they have had to be very efficient in their use of resources and they can actually not only survive but it sounds like and I haven't read the paper yet to some extent profit from the Medicare reimbursement rates.

So there may be a message there as to how do you then, or at least it gives you a direction as to how do I modulate the market power. And it is a role for having leadership.

I didn't think that the private pay years on their own can do that.

PROFESSOR STANLEY WALLACK: Okay.

DOCTOR STEPHEN SCHOENBAUM: Well, another approach, by the way, I mentioned that I didn't go into was price setting and transparency, and the only problem with that is that if people won't leave, let's say, the local area to even go next door then the fact that the prices are the same for all payers and everyone knows them but they are 20 percent higher 10 miles away still won't make a difference in the raw cost.

ASSISTANT ATTORNEY GENERAL LOIS JOHNSON: Just to follow up, in terms of -- I think one of the questions I was trying to get at are what are the measurements for measuring efficiency you mentioned that you sort of in your studies you looked at the use of efficiency or how states are with efficient use of resources and do you have any thoughts on metrics of efficiency of individual organizations like, for example, the use of total medical expenses or what other measures of efficiency can be used to ensure that practices are using resources in the best fashion.

DOCTOR STEPHEN SCHOENBAUM: It is a difficult area as I am sure you know and what we did and this is only a first step along the line.

We gave a grant now about two years ago -- the product I think has just been published by the National Quality Forum which is a frame work for the development of efficiency measures which is yet a step before getting to your question which is do I have out of the prow of Zeus or something, a set of really great efficiency measures. I think the other challenge is are we going to use the term efficiency the way it might be used or are we going to use it the way it is used in common parlance?

Are we going to refer to some relationship of quality and cost or are we simply going to refer to cost?

And I think that we ought to always have some idea of what the balance of those two is, and whether we deal with them together in one measure which is how I would ideally like to see efficiency measures and I think that those are very difficult to create or whether one looks at two measures together, i.e., how does one do in quality and how does one do in cost and then look at the relationship of those two which is a lot easier.

Is an open issue but it is probably going to go the latter way.

PROFESSOR STANLEY WALLACK: You know, I think your point is really good.

I mean I think you have got to put those two things together and I think you can look at quality improvements and then as you measure lowest -- you could look at savings on a total person basis.

So I think the point is putting them both together in some way but building them up is this idea, I think, we are all stressing about quality and needing a direct metrics about that.

There are a lot of questions, guys. Let me give you another one from the audience.

Would you please comment -- this follows some of the discussion you just had, Steve, more of the lessons learned on price and care setting in Maryland, West Virginia and elsewhere, what opportunities and risks would it present for Massachusetts.

DOCTOR STEPHEN SCHOENBAUM: Well, as I mentioned, Massachusetts has been there. It discontinued its process. I am not an expert in this particular area. We did have a paper. It has been published in the last six months or so maybe a little longer, I think it was in August, a paper by Graham Atkinson who is an expert and worked with the Maryland Rate Setting Commission for a number of years and is now a consultant in Washington D.C. who wrote a paper showing what the trends have been during the times that states have had or not had all payer rate setting processes of one sort of another in place and he describes each of those, each of seven states of which only Maryland and West Virginia persisted.

So I would refer people there and

if there is a residual question, I would be glad to connect whoever has it with somebody like Doctor Atkinson.

PROFESSOR STANLEY WALLACK: You are right. He started with the Maryland system when it first got started.

A plug for economists though -- the system was developed by an economist so each institution could actually set sits own price much like what you talked about based on its own cost. We wanted to do something to sort of get to the lower cost point but we also wanted to encourage managed care.

When you look at the Maryland system, you both have a tremendous growth in managed care very high rate as well as price regulation.

And, you know, it is really, I don't think we should think about competition and regulations being two things -- we have to think of either regulate the system or competition and I think they can be actually brought together and I think Maryland is great example of, in fact, where it was brought together and I have a paper on that that I can share with you.

So let me move onto one other thing here. What I found really intriguing, and I think by the way, you should know that this initial, this initial picture was developed by Tom Lee and Jim Mongan at Mass. General and then the Commonwealth Fund took the picture and actually made a very important modification in separating the payments, the bundling of payment from the pay for performance. I think that that is a really, really good idea.

What I was intrigued by and again because we are all talking about getting away from fee for service, and is this idea of you moving up, up towards the outcomes measures. I think you are right. We are now in the process measures and we have to deal with the service basis because we move to outcome measures.

We can start to maybe, you know, make a larger percentage of the total payment based on value -- based on outcomes. Would you give is a sense of what you think about magnitudes?

I mean I think the current pay for performance has small dollars involved.

What have you been thinking about in terms of the magnitude and how much we can move to an outcome based payment system as we go to more integrated systems. I am reading your diagram and I am excited.

DOCTOR STEPHEN SCHOENBAUM: Well, you know, outcomes, there are intermediate outcomes and there are sort of real outcome end points. We know that they are all variable.

So one intermediate outcome that is fairly close to down to the processes is re-hospitalization which I tend to think of as a real offense to a patient.

If you have ever been in a hospital and discharged, you expect that you have been taken care of and that that is the end of the process.

In most instances -- there are any

number of conditions you might have where you don't expect that you are going to bounce back, but, in fact, if you have a condition that you thought was taken care of but to now have an unexpected readmission which ought to be preventable is I think an extremely important event and it is a relatively measurable outcome although people are still working on what the measures are.

But we also know that mortality is a measurable outcome and that some hospitals are changing their rates of that -- the institute of health care improvement has been looking at this offer a couple of years now and there are certain -- there are certainly hospitals that have in their terms moved their dial, so that is an outcome as well, that one can talk about and it is one that is rather important.

PROFESSOR STANLEY WALLACK: Absolutely, those are very good measures, but I was actually intrigued by the percentage of the payment that it could be based on outcomes or value rather than just paying on the basis of volume.

Is that -- throw it out -- if we move from 1 to 2 percent on pay for performance -- we do it on process measures to 25 percent when we move to outcome measures when we have integrated systems?

DOCTOR STEPHEN SCHOENBAUM: First of all, I am not sure that one or two percent is working. I think that that is the problem with integrated health care issues in California.

So, yes, I think you are probably talking about double digit percentages possibly both for processing and for outcome.

And, again, I am not sure why there should be any particular problem with that. It is just that if you are trying to balance let's say these different modes of payment and some kind of blend, then you don't want one to be 98 percent and the other 2 -- whichever way it goes.

PROFESSOR STANLEY WALLACK: Let

me ask at least one of my questions and I maybe I will look through the cards at the same time. I think we are running out of time. I got your message here.

I think you start off at the front of your talk with talking about patient centered care and how important that is as we move forward.

And we had a wonderful discussion I thought on our first day Tuesday with a consumer panel talking about wanting to be involved, just the things you said.

You know, they wanted to be a stakeholder, they had really good ideas, they wanted to contribute to the debate. Yet I think when you look at a model like this you don't see the patient and yet when we think of high performing organizations in the non-health area and you think of those, the best practice ones are always ones that know their client. They are the ones that know the market, they are the ones that know the client. The apples of the world -- and they deliver to them. It is very demand focus. They are looking at that whereas a lot of what we are seeing coming out is very much supply focused. I mean organization, doctor driven.

Can you give us an example of a really good system -- we are not going to ask you to identify it -- but a high performing system where the patient is really at the core of it and what does it require to get us there?

DOCTOR STEPHEN SCHOENBAUM: First I think to go to what it requires, it requires the same kind of thing it takes to get us towards perfection and safety and to very high use of effective procedures and so on.

It requires commitment either at the very top of the organization by the CEO or by someone with enough power to make change happen within that organization. So, I don't think it can happen solely from the grass roots of an organization. It ultimately has to involve the grass roots and involve everyone in it but it is really part of a whole culture. There are organizations that do it. I think if you are the one that comes to mind that is a couple of miles from here is now the Dana Farber where patients are involved, as I understand it, on virtually all of the important committees of the organization.

And when they were searching I am told I think I remember this story correctly, that when they were searching for their chief operating officer after Jim Conway went to the Institute for Health Care Improvement one of the candidates said why there was a patient or a family member involved in interviewing me and that was a disqualifying question as I heard the story which was that, you know, the kind of person that was required by the institution for that role was going to have to be somebody who already was bought into the idea that it was really important for patients to be involved in all of the key processes including the selection of the next chief operating officer.

PROFESSOR STANLEY WALLACK: I have the last question and I am going to add my thought onto the end of this one so just to prepare you for that it is going to be a two part question for my last question.

A question from someone here -- is there any country that the Commonwealth Fund has studied that performs better than the U.S. that does not use some type of global budget or cap on total spending as a means to control? I want you to answer that question and given your experience and work in Great Britain -- why don't you use Great Britain as an example -- because there they are really trying -- not only the global budget but they are trying to work on quality and they are using the concepts of lean manufacturing and they are really emphasizing the patient.

So maybe you could talk about the global budget on the one hand with any other countries but also talking about even within global budget how they really orient themselves to the patient and England is a good example of what is going on in Great Britain.

DOCTOR STEPHEN SCHOENBAUM: I am having difficulty with the first part which is that I am not coming up with a country that doesn't have some way of at setting the least spending targets.

PROFESSOR STANLEY WALLACK: I will give you that.

DOCTOR STEPHEN SCHOENBAUM: That is not necessarily the same as having a single payer.

PROFESSOR STANLEY WALLACK: Right.

DOCTOR STEPHEN SCHOENBAUM: And exactly one budget. So you do have countries like the Netherlands where they have now an entirely private payer system but it is a very regulated group of papers and that undoubtedly effects --

PROFESSOR STANLEY WALLACK: There is that example again when they created competition within its overall budget.

DOCTOR STEPHEN SCHOENBAUM:

Correct. So there is that and I am missing the first part.

PROFESSOR STANLEY WALLACK: No, that is a good answer.

I was going to ask you to talk. I think what England is doing now is probably a most interesting thing that is going on with regards to lean manufacturing and lean production where to do that you really emphasize the patient again.

I am very much interested in how we move to a demand side approach on this and to the patient.

I want to know if you can comment on your view now what is going on in Great Britain. That is the last question.

DOCTOR STEPHEN SCHOENBAUM: Yes, somehow I am reminded that whenever you mention that one of my other roles -- I am on the Board of the Picker Institute and while we are not responsible for something called Picker Institute Europe which is based in Oxford, England, there is one and that organization is one that is interested in patient experience both in terms of providing outcomes information and there are certain things that you can only learn from patients, and also for optimizing patients' experiences.

The National Health Service a couple of years ago probably because it is patients vote in England and there is a National Health Service, seemed to have an epiphany, and felt that it was really important to emphasize patient experience and patient centered care in all aspects of the care that was being delivered.

And I think that there is evidence and I just got a bulletin from Picker Institute Europe yesterday that patient experiences in a variety of settings -- this one was about an ambulatory care -- are improving over time. That the trend is to improving but again it is a central concentration and it is as if they had set a goal and if I have a valedictory remark that I can make it is to go back to the idea of setting goals that I mentioned in the testimony that there is no reason why that can't be done at a governmental level, but it would be an inclusive process and I would also go a step further which I didn't mention in the testimony and I think that there can be certain standards that are set for performance and that there are standards that would enhance patient centered care, coordination of care, potentially decrease cost or improve quality and I will give you an example of those which is that I would think that every patient who goes to an emergency room ought to be discharged with a legible set of discharge recommendations that also sit on the desk of their primary physician assuming that they have one. 90 something percent of Americans do say that they have a doctor, that there be something that sit there within X number of hours, you can set X.

Today physicians don't necessarily know when their patients come to the emergency room. There are hospitals, and I see the CEO of one of them in the room why, in fact, computerized summaries are given to people and they are legible but that doesn't happen everywhere in the United States. It is not the standard practice and I suspect it is not in Massachusetts as well.

PROFESSOR STANLEY WALLACK: Listen, Steve, this was great. I appreciate you taking the time.

Thanks you for all of the work.

(Applause from the Audience.)

COMMISSIONER MORALES: Thank you, Professor Wallack and thank you Steven Schoenbaum.

We are going to take a two-minute break while we organize our next panel.

(Short Recess.)

COMMISSION MORALES: If we could get started, again, thank you, Attorney General Martha Coakley for being with us today, Representative Mary Grant, Vice Chairwoman of Health Care and Financing, the Representative.

Before I get started I want to

introduce Michael Bailit who will moderate our panel, but first I would ask the Stenographer if you don't mind to swear in the panel.

THE STENOGRAPHER: Would you all stand and raise your right hand.

Do you solemnly swear that the testimony you about to give in the matter now at hearing will be the truth, the whole truth and nothing but the truth, so help you God.

Please identify yourself by raising your hand if your testimony today is limited for any reason, there are any restrictions placed on the capacity in which you testify here today, you have any conflicts of interest that require disclosure.

(James Roosevelt, Jr. raised his hand.)

THE COURT REPORTER: The Division requests that you submit a written statement for the record disclosing your specific restrictions or conflicts by 3/26/10.

MR. JAMES ROOSEVELT, JR.: The statement will simply identify that I am speaking for myself and for Tufts Health and although I am Board Chair of the Massachusetts Association of Health Plans, I am not speaking in any authorized capacity for them today.

MR. MICHAEL H. BAILIT: Good morning everyone.

This panel has been created to discuss the health care delivery system in the context of costs and cost trends.

The members of the panel are Phil Gaziano, the Medical Director of Hampden County Physician Associates; Jim Roosevelt who just introduced his affiliation and Paul Levy, President of the Beth Israel Deaconess Medical Center; Don Goldmann, Senior Vice President for the Institute for Healthcare Improvement; and Jack Dutzar, President and Chief Executive Officer of the Fallon Clinic; Barbra Rabson, Executive Director of the Massachusetts Health Quality Partners; Barbara Spivak, the President of the Mount Auburn Cambridge IPA.

I am going to ask the panel at the

outset that you please speak clearly. I will direct questions individually to you. While you may be tempted at times to want to jump and respond to one another I want you to ask you to please respond from doing so as there are question a few questions I would like to get through with you today. The focus of this panel is, of course, going to be on the delivery system but specifically what are some of the problems that we experience in the delivery system that contribute to health care costs, and so I want to put a little less emphasis on solutions and a little bit more on problem identification today.

I would like to start in the context of the charts to my right and the reports that have been issued by the Attorney General's Office and the Division of Health Care Finance and Policy with a few questions specific to market dynamics and that being market dynamics primarily and not exclusively between payers and providers in Massachusetts and how they contributed to growth and health care spending.

So these recent reports are articles in The Boston Globe over the last year and-a-half and other publications have talked to market dynamics in Massachusetts and how they have contributed to cost growth.

The Urban Institute did a brief on our cost problems about a year ago, a little over a year ago. In it they wrote there seems to be little evidence of active competition on costs and prices between dominant players and with other hospitals in there local markets.

The cost growth in the state is driven by market power of the leading systems.

Now in the context of these graphs we might want to dispute whether it is only leading systems and perhaps we might also extend the concept not just to hospitals but to other providers of services, but I would like to ask first, Jim, whether the lack of price and quality competition among providers is a primary driver of health care cost growth in Massachusetts.

MR. JAMES ROOSEVELT, JR.: Are we permitted in this section to make -- to give our testimony?

MR. MICHAEL BAILIT: Your testimony -- I am sorry -- I forgot and I was so eager to ask my questions. So remember that question.

And let me first allow you to give your testimony, so please give your testimony in three to five minutes and we will come back with that question. I will start with Jack here and we will just go down the table.

DOCTOR JACK DUTZAR: Good morning, everybody. It is a delight to be here representing our organization and be here with you on this enormously important subject.

Thirty years ago when I first started working in health care management, I learned by first joke which went something like cost, quality and access -- pick any two.

Over the years, I have been more than convinced that nothing as complex as the issues that we have in health care delivery can be reduced to anything quite that simple.

What I do believe, however, is that there is some truth in it in the sense that we spend our time managing those three elements and they are always inextricably linked to each other.

We are here to testify today regarding the costs of health care, and what drives that cost and what we can do to bring it under control.

Speaking for our organization, the Fallon Clinic we have a longstanding commitment to focus on that topic in service to our patients and to the communities which we serve. Our mission state includes the phrase "appropriate use of health care resources".

The Fallon Clinic is a free-standing multi-specialty group practice of nearly 300 clinicians and just under 200 employees in central Massachusetts.

Nearly two thirds of our 200,000 patients come to us with coverage that is for prepaid care or otherwise -- for us comfortably known as capitation.

We are strong components of capitation as a preferred method of reimbursement primarily because it allows us to focus on the clinical needs of our patients and to invest in health care delivery structures that support them especially patients who are most vulnerable. Our incentives are to keep our patients healthy and provide them with all of the health care that they need.

We believe both that we are fundamentally more efficient than most of the systems around us and that we have much, much more to do in achieving a higher level of efficiency.

The somewhat opaque nature of the relationship between payers and providers however keeps us from knowing and placing ourselves on a continuum of how inefficient we are and to what degree we may be part of the problem.

Our current level of efficiency at our current level of reimbursement is not leading to significant margins.

My personal message is our Commonwealth considers options for controlling the costs associated with our commitment to universal coverage and our very highly regarded care delivery is to not forget the lessons of the past even the recent past.

Fee for service reimbursement provides access but it is a fundamental factor in increasing costs.

Managed care in its many forms can control the trends. Between 1993 and 2000 it has been estimated that the United States saved over a trillion dollars in treaded health care costs during the expansion of managed care and H.M.O. products.

When providers are at risk,

however, they rely on incentives that create real improvements in costs and quality.

The declining managed care across America after 2000 was due in large part however to the public's reaction to poor access and poor quality.

The reason for access and quality issues were at least in part because the strategy placed excessive risk on providers who were unprepared and not structured to manage that risk.

I believe that the sweet spot we are all seeking will be hit only with a thoughtful collaboration between payers, providers and patients around how we manage to balance the three parameters of healthcare -- cost, quality and access.

Many of the current strategies being pursued will in my opinion lead us, again, to a backlash and not the future we all hoped for.

Global payments and prepayment is a recommendation in front of us and we at Fallon Clinic support that recommendation in the strongest possible way.

Our success, however, will be found in the details of how we implement those recommendations.

Externally applied cost controls and I appreciate the presentation in the prior hour, but nevertheless, if we make that choice, then we should always be aware that it will have a significant potential impact on the other two parameters, quality an access.

Finally, continuing and balance of reimbursement for attachable values of representation and/or market dominance will also hurt our efforts to being affordability and stability into our nation-leading efforts of our state to provide quality and access to all residents of the Commonwealth. Thank you.

DOCTOR PHIL GAZIANO: Thank you. It is amazing to see everyone coming together to share ideas on a topic that many will find different points of view.

I am one of the medical directors

of our physician group and our physician group has helped put together networks of about 700 physicians which have been working with global cap contracts for about 12 years.

After practicing for 20 years myself, and leading providers in different systems, I and some of the 700 or so physicians in our global capitation networks have noticed impediments to delivering quality and efficient care.

These drive-up costs and reduce quality and we are ready to move to different systems that will allow us to practice the way we know we can.

Most of the impediments are caused by systems setup in the past by well meaning individuals. One example is the Federal regulation requiring fee-for-service Medicare members to stay three days in the hospital even if they don't need it, and expose them to certain risk if they need to go to a nursing home or rehab unit.

If the I tent was to protect these

individuals, the effect was to increase costs and potentially reduce the quality of the care delivered.

And now there is a new Massachusetts regulation enacted in July of 2009 that requires a legal guardian be appointed for cognitively impaired patient before admission to a nursing home or rehab unit.

I have a patient in the hospital now that came in in the middle of January, and should have gone to a rehab unit the week after admission but due to this regulation and our overburdened courts, my patient is getting the wrong type of care at taxpayer expense and is still in the hospital.

Despite these, the largest impairment to efficient quality -- to efficient care and high quality is the way we pay providers. The health care debate should not be about how many payers there are -- single or many or whether they are public or private but what is the best payment methodology to teach and produce the highest quality and most efficient health care.

I and many of the other providers in our networks have delivered care using the four most common systems. These include managed care with outside managers, sometimes out-of-town and out-of-state telling us how to practice, partial capitation, fee for service and finally global capitation with management done by the clinicians caring for the patients.

The last one is the only one that we believe will help us reach our desired quality and efficiency goals.

Payment systems with outside managers tend to fail since the managers, however well trained and well intentioned are less knowledgeable about the particular needs of my patient.

The outside guidance whether from private or public managers also causes resentment and feelings of decreased control in both patients and providers. And inevitably some mistakes are made. This is not to say that there is not a valuable function for insurance companies to -- and governments to help guide us. The second partial capitation system including those for medical home will not address all of the patient's needs and should not be -- should not be the only basis for payment reform. It can provide new techniques and will be helpful but won't give us our goals.

The third payment and the one that the fewest resources devoted to prevention and quality fee for service but that is what our doc use most right now.

A possible example of over testing is when President Obama received a coronary calcium test which did not change his recommendation to quit smoking or reduce cholesterol.

The real risk to him was not the extra radiation which is a year's worth of background radiation in 15 minutes but the fact that the low score can reduce the tendency to actually stop smoking and do the prevention.

The last payment methodology and the one with the most to give resources to prevention and quality, global capitation with local clinical managers.

Our group in partnership with health plans and hospitals and the other specialty providers in our network have been practicing with these for 12 years. It is also the one that our providers like the most because it affords more time to spent with your patient and pay attention to all of their needs.

When the special commission recommended accountable care organizations, we noticed that most of the findings and recommendations for those we had been using for 12 years.

If you put quality first and the infrastructure is not achieved, you will achieve both improvements in quality and efficiency.

I now believe those that think it will take five years for our state to make the transition to global capitation don't understand the ability of our providers to make the appropriate change. We have seen firsthand the improved health, the reduced cost and improved satisfaction that the ACO type network can bring. All care is managed -- either managed well or poorly. Fee for service systems do not promote or fund the infrastructure for well managed care. Our current global capitation networks better support new PCPs give additional benefit and quality care to our members and save the community money.

We have found that the 20 percent of waste is probably true. And we are ready for the rest of our patients to move towards these programs.

DOCTOR DONALD GOLDMANN: Good morning. I am Don Goldmann and thank you, Commissioner Morales for inviting me to testify on behalf of the Institute of Healthcare Improvement.

I am going to focus my remarks on systems improvements that I think are required to both increase the quality of care and reduce costs. I want to emphasize we are talking mainly about health care but the ultimate goal is improved health and we should be doing a better job, all of us of measuring the health status and functional status and healthy life expectancy of the citizens of the Commonwealth.

So I am going to touch on ten points briefly. There is a bit more detail on the posted testimony and I am going to give some cautions and caveats as we go.

First, not surprising that I would bring this up -- improved patient safety and reduce harms.

Great progress has been made in reducing the rate of costly infections in hospitals through reliable performance of evidence-based practices but there is still room for improvement.

Hospitals also need to be working on other avoidable harms such as pressure ulcers, falls, venous thromboembolism and so forth.

Now with that said, here are some cautions.

Focusing on individual harms certainly is beneficial and lifts our collective spirit when we see progress but it is inefficient and may have significant opportunity costs by shifting hospital resources from other quality and safety issue.

Harms prevention needs to be addressed as a system property, part of a broader effort to transform the way we were so that overall rates of harm and mortality actually decrease.

Patients want to know that they will be safe when they go into a hospital. They will have no harm period. They don't want or need to understand and pay attention to multiple types of harms when they go in a hospital.

Efforts to improve safety should not focus only on ICUs or even the hospital as a whole, the risk of harm extends well beyond the hospital walls.

For example, long term intravenous catheters inserted in the hospital carry substantial risk of infection and thrombosis after the patient leaves.

Errors of commission are no less important than errors of omission. A 60 year old patient who does not receive an indicated colonoscopy and shows up with colon cancer and a patient who has a severe wound infection following colon surgery, both have suffered terrible harms. The second point is reducing hospitalizations, rehospitalizations and Emergency Department visits.

The Commonwealth is taking a leadership role in addressing these issues especially re-hospitalizations but there are major remaining challenges.

The maximum benefit will be achieved only if care improves across the continuum.

Avoiding encounters with acute care systems is a shared responsibility and currently neither hospitals nor providers are rewarded for avoiding rehospitalizations.

Patients, especially those with complex medical and social problems must be supported across the care continuum. We should capitalize on promising opportunities to engage navigators, health coaches and community services to support patients outside of the hospital.

Some of this assistance can be provided by trained professionals who are not highly paid health care professionals and I think we need to do a better job of leveraging the technologies that are becoming available such as home health monitoring.

The patient centered medical home is only a partial answer and by itself can't be expected to magically support patients at home or across the care continuum without other supports beyond the office setting. Realizing the promise of the medical home will require payment reform and a substantial shift of resources to ambulatory care and community services.

The biggest cost savings will come from improving the continuity and the quality of the care for the socially and medically complex patients as we all know. And there are many promising approaches to do that but it is equally important to identify and intercept those patients who are less ill right now but will move into the more medically complex and costly category in the short term if we don't do much about them.

The third point is reduce the overuse of drugs and technologies particularly by specialists. Even though the terms overuse and waste are distasteful to providers and often misunderstood by patients, the evidence for unacceptable variation and overuse of diagnostic and therapeutic modalities is very clear.

As we debate how to reduce the use and reliance on these technologies, I want to acknowledge that there is a bit of beating the technology companies and pharmaceutical companies -- without those advances, things that were achieving today like getting to almost zero in central venous catheter and ventilator associated infections would not have been possible. The stiff catheters and the technology that I used 10 or 15 years ago would not have done the job no matter how much quality improvement we did. So let's be a little realistic on the role of technology.

That said, based on the Heller School data there appears to be an urgent need not just to understand the over-utilization of technology but the relationship between price and cost in Massachusetts.

Focusing only on utilization which we tend to do may be problematic.

There are two issues we need to confront when thinking about the price cost continuum.

Even though some technologies have become virtual commodities and volume of use has skyrocketed, price has not plummeted.

Health care seems to be a unique industry in which increased supply fuels increased demand without much impact on prices.

More importantly, patients have no way to understand the true cost of almost any aspect of care they receive and much greater transparency and simplicity are critical.

Fourth, reduce waste in the entire health care system by streamlining care in whatever method you want -- lean -- or I don't care what it is -- it just has to be done.

Go into any hospital today or any office and you will see waste due to specimens that are lost, redundant use of drugs, redundant and overuse of procedures. Even worse is the time wasted by providers and patients and the delays they experience in receiving appropriate care.

Fifth, deploy HIT in scale. There is abundant evidence that at least theoretically this dramatically reduce costs and improve quality but to achieve meaningful use and improved clinical outcome HIT must be complemented with clinical systems redesign forcing EMR or CPOE into the current flawed delivery system will lead to frustration, rework and even unintended consequences and I hope that the Massachusetts Regional Extension Center that has just been funded by ONC will take this very seriously.

We should consider redesigning HIT systems from the perspective of patients rather than providers.

Sixth, we should be testing regional solutions to improving quality of care and improving health and controlling per capita costs by paying special attention to the health component because we can tend to silo it since the time horizon is so long to achieving the cost mitigation from improving health.

Calculations of health care costs should also include infrastructural things we need to do such as the build in environment, community service, sanitation and foot.

Seventh, accelerate tort reform -- I won't dwell on that. We all know that physicians are practicing defensive medicine and spending money to do it.

Eighth, think of health care expenditures as coming from a common pool of resources, ultimately these costs are born by the individuals living in the community, all of them, but citizens don't think about health care in this way.

We have done a relatively poor job of mobilizing the public to think differently about the consequences of sustainable increases in health care costs for both them and their children.

Ninth, we need more emphasis on the how of getting from here to there. I doubt that we will achieve our goals magically through legislative mandates, public reporting, pay for performance or pre-market forces.

Providers and patients are just going to be need to be coached on how to achieve these aims using systems improvement.

And, finally, I don't want to hear about any efforts to contain costs and improve quality that leave anybody behind and the safety net has got to be in front of us every time we discuss this issue.

Thank you.

MR. MICHAEL BAILIT: Panelists, I just want to remind you of our three to five minute time frame. I have little flash cards here to remind you.

MR. PAUL LEVY: Thank you, Commissioner Morales, for inviting me. And to you and to Attorney General Coakley, I just want to express my appreciation for the excellent work done by your staff for preparing for these hearings.

It is clear to me from the report prepared by the Attorney General's Office and testimonies submitted by witnesses to the Division that the reimbursement system is broken in Massachusetts.

I think most of us would not find

it societally appropriate that the amount that physician groups and hospitals were paid for their services would be based on market power as opposed to the underlying characteristics of the population being served and the cost structure required to serve them in that population.

There is an insidious result from the current payment system which is that the systems and hospitals that receive higher payments are more likely to recruit additional physicians into their networks thereby causing the greater referral volume to those higher priced systems, and in combination those long term results are in my belief a major contributor to the increasing cost of health care in Massachusetts.

As Professor Schoenbaum has mentioned, and I think there are three steps that can be taken to help with that problem.

He very perceptively noted that the private payers cannot be expected to solve that problem on their own and, therefore, state action is required.

The first type of state action is the type that we started to see here on these charts, some transparencies, some sunshine on the actual rates being paid.

A second approach would be to move to all payer prices. This would require I believe the Attorney General's involvement so that anti-trust concerns are alleviated. My proposal on this is that we should start to move all of the providers to the statewide average rate as a start.

A final step along that continuum would be the actual rate setting process where it is an administrative law process similar to what is used in the public utility arena.

As Professor Schoenbaum has mentioned, Maryland and other states have done that. There are pros and cons of that but it is certainly worth taking a look at.

Another area that I think we need to address is the medical arms race problem, the idea that all hospitals or a number of hospitals feel they all have to have the latest equipment and offer all forms of service.

We have, as an example, duplicative, highly duplicative programs even in the Boston area in solid organ transplants. There are insufficient organs, livers, kidneys and pancreas' to justify the number of solid organ transplant facilities that exist within five miles of this building today and there and in other cases is an opportunity for state action to simply tell the hospitals, some hospitals that, no, they cannot provide certain services.

Getting to the issue of high performance organizations, Don Goldmann said this very nicely.

I would like to address it in two respects. One is internal to any given organization -- first, I would like to disagree with Professor Schoenbaum about the idea that there is not a financial incentive under fee for service systems for quality and safety improvements. There are indeed financial incentives for doing so and there are many opportunities to achieve improvements there.

Also, as Don suggests, you just can't stop with quality and safety improvements. There needs to be a transformation with the way work is done in the hospital or in a physician's office setting -- that requires a respectful engagement of staff people throughout the organization in the hospital from the transporters and the food service workers all of the way to the neurosurgeons who are empowered and urged to call out problems in the work environment to adopt lean approaches or other approaches like that that are highly respectful of those workers to gain from their experience in pointing out problems.

And the final aspect, of course, is an increase in patient and family involvement in the governing and operation of processes of those hospitals.

On the external front for any given

hospital the relationship between that hospital and affiliated -- and physician groups and community hospitals in its service territory -- I am talking now from the point of view of the academic side are extremely important and that that relationship should be based on mutual respect and information technology connections but should basically be designed to have patients get the care that they should get in the right place whether it be in the community or in that tertiary setting and that can -- that is an important part of controlling long term health care costs in the state.

Thank you.

MS. BARBRA RABSON: Good morning and thank you, Commissioner Morales, for the opportunity to speak on this panel today.

My name is Barbra Rabson and I am the Executive Director of the Massachusetts Health Quality Partners.

Efforts to manage costs and improve quality have been going on for decades, but they are too often stymied by the way the health care system is currently organized, financed and, in effect, segmented but there is an emerging consensus, however, that we need good quality measures and we need transparent quality cost data in order to close this value gap.

If you can't measure it and report it, you can't manage it. It can't be improved.

So the role of my organization and my role is to produce reliable performance information and that is what I will focus my comments on today.

The Massachusetts Health Quality Partners is a coalition of physicians, hospitals, health plans, purchasers, consumers, academics, and government agencies that have been first established in 1995 by a group of health care leaders who identified the importance of valid and comparable measures to drive improvements.

MHQP has a successful track record for reporting trusted healthcare performance information and we provide the information both to the physicians to help improve the care they provide their patients and to give this information to the public to help them better inform their health care choices.

To date we have issued eight, excuse me nine public releases of performance information -- eight with physician performance information and one on the hospital side.

We believe that transparency plays an important role in making our health care system accountable and provides the public with tools to better inform health care choices.

In fact, in a commentary released yesterday by Doctor Lucian Lee who is an internationally recognized leader in patient safety, he argued that of the three major approaches to improving patient safety, regulation and accreditation, financial incentives and public reporting and performance and feedback to health care providers, it is the public reporting that holds the greatest promise.

MHQP measures performance in three categories -- measures and tests whether the recommended services are provided. This looks at underuse of measures and makes sure there is preventive screens; measures and tests whether certain services are only when they are appropriate, this looks at overuse of measures and services; and surveys that measure the aspect of care from the patient's perspective.

Each of these quality measures can ultimately impact the cost of health care and should be shared both with providers being measured and with the public.

And below are some examples of these measures that impact the cost of quality of care.

If you look at some underuse measures such as the management of asthma and cancer screening, we can see, for example, how well physicians provide recommended preventive services for colorectal screening. Screening tests can detect colorectal cancer earlier in the cancer as Doctor Goldberg has said and that can lead to more successful treatment.

In MHQP's most recent report, there is 43 point range from the highest performance medical group to the lowest performing group. The highest performing group, 92 percent of the time performing the screening when prescribed or recommended and the lowest performing at 49 percent of the time.

An example of an overuse measure is to make sure services are used appropriately is physician use of imaging studies when appropriate for diagnosing lower back pain. Most patients with low back pain improve with conservative management and do not require immediate diagnostic study. Yet MHQP's report identified a 45 percent point range in appropriate use of imaging studies for adults with low back pain. The highest performer had a score of 97 percent while the lowest performer was 52 percent. This is clearly a very important measure and we need to narrow this gap.

I will say that over time as MHQP measures these, the gaps do narrow over time so it is effective.

Finally I want to talk a little bit about patient experience. Patients are the best source of information for certain aspects of care and Steve Schoenbaum had talked a little bit about that.

So what MHQP measures is how well doctors communicate with patients. Clearly good communication is strongly linked to positive health outcomes.

Patients are more likely to follow prescribed recommendations if they feel their doctors are listening carefully to their concerns and showing respect for what they say. How well doctors coordinate care -- patients are also asked about whether the doctors keep informed and up to date about the care that they are receiving from their specialty physician after referal and 40 percent of the patients reported that their P.C.P. was not always informed and up to date about the care they received from specialists leading to discontinuity and possible poor decisions.

Finally, how well patients are able to get timely care and appointments and information -- when patients receive care in a timely way, particularly around chronic diseases -- they may avoid emergency room care and hospitalization.

So to conclude, Massachusetts will only achieve the goals we have for a high value health care system if we have reliable and transparent cost and quality measures to drive improvements and behavior change and these measures will need to be linked to payment systems to reward high performance. Thank you.

MR. JAMES ROOSEVELT, JR.: I am Jim Roosevelt from Tufts Health Plan and contrary to what you may have read in the State House news in the last few days, I am still President and CEO of Tufts Health Plan.

I do want to thank you,

Commissioner Morales, for the way you have organized these hearings and I want to thank the legislature and the Governor for mandating these hearings. They are a very important part of our achievement, our historic achievement in bringing about near universal coverage here in Massachusetts at a cost at or below that was projected contrary to what you may have read in the last few days or repeatedly on the Op Ed page of The Wall Street Journal.

Tufts Health Plan insures approximately 740,000 residents in the Commonwealth and is ranked the Number 3 health plan in the nation by our national quality accrediting body.

My testimony will focus on delivery system reform, the drivers of medical cost inflation as well as some solutions and potential challenges moving towards a more efficient and higher quality care delivery system.

First, the problem, the report recently released and tremendous work has been done by both the Division with its report and the Attorney General's Office with their report concludes that the period -- that for the period study 97 percent of the total member per month premium growth from 2006 to 2007 was attributable to medical claims. They makes it clear that the only way to reign in premiums increases is by containing medical claims costs.

We also know from the reports that unit price or the price we paid per service is responsible for 75 percent of medical inflation, while utilization contributes about 25 percent.

The conclusion we draw from these reports is that the solution to cost control will require a more rational alignment of incentives and a possible realignment of prices that results in more affordable access to coverage.

We have heard a lot over the last several months and in particular over the last couple of days about the problem. Let's turn to some solutions. The special commission on payment reform recommended that global payments become the predominant form of payment here in Massachusetts.

We support that recommendation and concur with the commission that the transition should occur within a period not to exceed five years.

Tufts Health Plan has considerable experience with global payments and in particular in our senior products segment.

Approximately 22 percent of our commissional, that is non-senior HMO membership is covered under our risk-based arrangement including capitation, however, nearly 100 percent of our Medicare H.M.O. members is covered under these same type of arrangements.

We believe that global payments or capitation arrangements when appropriately structured can result in more efficient and higher quality of delivery of care and our results show this.

In a recent analysis contracting Medicare advantage plan to traditional fee for service Medicare, Tufts Health Plan had significantly lower rates of avoidable hospitalizations and unnecessary emergency department visits relating in both costs savings and improved patient care.

Tufts Health Plan's rates for preventable hospital admissions and preventable emergency room visits are well below the national average for Medicare beneficiaries.

It is essential that we acknowledge that global budgets in and of themselves may not correct for the variation in unit price -- at least not in the near term.

I believe before we make these bold transitions to global budgets our efforts should be focused on the variation in unit price.

There are two proposals currently under consideration by the administration and the legislature which could have an immediate effect on unit price and, thereby, premiums rates and the affordable health plan introduced into the legislature by

Chairwoman Stanley who is here and Chairman Moore limits provider prices to 110 percent of Medicare and insurer underwriting surpluses to two percent -- that would result in an average premium decrease of around 22 percent.

The affordable health plan is effective in reducing premium rates because it caps unit price at 110 percent of Medicare.

This proposal is a short-term solution designed specifically for small businesses that are in dire need.

A second proposal House Bill 4490 requires carriers to offer a limited network product.

I am running out of time so I am not going to be able to go into a lot of detail.

I will point out that in eastern Massachusetts limited network products have not been popular. Tufts Health Plan offers one but it has not been widely accepted by members. Neighborhood Health Plan is the only other example in eastern Massachusetts. Fallon Health Plan offers one successfully in central Massachusetts.

So, in order to address the problems that we are facing today, we think we have already demonstrated the global budgets can be effective and we believe the five years is a reasonable time frame.

I will expand on these thoughts in our answers to questions.

DOCTOR BARBARA SPIVAK: Thank you for inviting me, a representative of the IPA. I represent Mount Auburn Cambridge IPA. We are a small IPA of 500 physicians. We represent 50,000 patients with global capitation products in Blue Cross, Tufts, our Medicare advantage product is the Tufts Medicare advantage product and Harvard Pilgrim and Fallon.

Our physicians see the rest of their patients are paid on a fee for service basis. So they live in two worlds.

We have discovered about 15 years

ago in doing global capitation that we were actually were taking a ton of risk and doing nothing to manage that risk.

So about 15 years ago we began to develop a culture and series of programs would help our physicians both improve the quality of care that they deliver and become more effective in the care they deliver.

We believe there are certain elements that have made us more successful than the average IPA. Those include -- not in any particular order -- that we are very primary care doctor-centric.

We have a primary hospital. It is Mount Auburn Hospital. They are a risk partner. They share in both the costs of running that program as well as in the benefits when we do well on a global budgets.

They as well as the organization are very much geared to promoting the primarily care base of our system.

We are organized in a way that we educate our primary care doctors and we help them provide better care.

Our programs include a pharmacy management program, a quality improvement program, we are putting in place an electronic health record system that in the next year or so we hope will integrate us more fully and we have a sophisticated case management program that depending on the health status of the patient provides them with either no case management services to the totally healthy but provides quite intensive services for those that are quite ill.

We case manage our patients when they are in the hospital as well as when they were in the SNIFS and in the community as well as in acute rehabs.

We believe that some of the reasons that capitation failed in the past is the view of both patient and providers was that capitalization was only to limit services and that there was no infrastructure in place to help them improve care and improve quality and improve efficiency.

So we have tried to do a different level of service. We have over 40 employees for the 50,000 patients that we manage.

Now a good number of those are implementing the electronic health record but that is also as you have seen in the data presented here an important part of making us a more effective organization.

We believe that capitation failed because budgets weren't adequately developed and that there was no money or resources put into developing the infrastructure that we have developed.

It takes time, money and a commitment by leadership as well as the health plans and the state to develop the kind of community and culture that we have.

You have already heard from providers that access to networks is critical. You can't ask for a global capitation unless patients and providers and their hospitals incentives are all aligned to keep the business together in one location in one network.

We believe that we have done that by marketing to our specialists who are primary care doctors. So we make it a very important part of our educational process that all of our doctors know what we are doing, and that the quality that we do at our hospitals is equal to or better than what is happening downtown with all due respect to my downtown partner.

MR. PAUL LEVY: We are not downtown, we are at Longwood.

DOCTOR BARBARA SPIVAK: At the end we believe that global capitation, the development of ACOs, medical homes, whatever way you want to call it, is the right approach but it has to be done carefully and with tremendous thought with aligning the incentives for patients, providers, hospitals and health plans and given the amount of time and resources to develop the kinds of programs that we have developed.

MR. MICHAEL BAILIT: Thank you all.

So, if you can remember, Jim -- I

want to give a little context with the question now.

Several of you have talked about the benefits of global payment and as Barbara just spoke to integrating how providers deliver care. But even if that becomes normative in Massachusetts following the recommendations of the special commission, it seems to me that the question I originally asked about the extent to which lack of market competition drives costs and price is still relevant.

So let me ask you both in terms of today and prospectively tomorrow, the extent to which lack of competition is a primary driver of pricing costs.

MR. JAMES ROOSEVELT, JR.: Let me just start to answer that with actually my favorite health care joke when I first became a health care lawyer back when it was called hospital law before anyone even thought of calling it health care law.

A brand new hospital lawyer was walking on a beach and found a bottle and pulled the cork and a genie comes out and says for releasing me you can have one wish and the lawyer being a responsible citizen says peace in the Middle East and the genie says that is much too hard, try something else and the lawyer said, well, explain the American health care system to me and the genie said let's go back to peace in the Middle East.

I think that there are many factors as we are hearing here that lead to the situation we are in today. I do think the hidden gem of universal coverage is just what we are seeing that health care costs are now a matter of public interest not just a food fight between providers and payers.

Competition has at times in the past played an important role in health care pricing. That has become less true over the last two decades.

In the '90s, it is demonstrable that managed care not just because of case management and appropriate use of care, but also because of pricing competition, lowered prices here in Massachusetts and elsewhere, several things then happened.

There was a -- there was a significant provider consolidation. There was a change in the legal relationships as there was the backlash against managed care nationally.

And in particular things that were referred to in a master stroke of political phrasing as patient bill of rights. And there was not yet the increase in information that we are now seeing. And information is key to competition.

There is the risk when you have provider consolidation that information will simply lead to a race to the top on pricing and that is where there is going to have to be a thoughtful and significant, I believe, governmental action as well as strong private sector -- strong private sector role in making pricing -- in negotiating prices to make competition once again a positive factor.

Something that takes place in most

markets in this country is the use of select networks or limited networks to use the more pejorative term, that is not all providers in every insurers network -- that shifts the leverage and implements competition. This market --

MR. MICHAEL BAILIT: Can I follow up?

So is a primary reason why you have not been able to negotiate more effectively on behalf of employers and consumers the fact that you can't offer a limited network and you are compelled to include every provider in every network?

MR. JAMES ROOSEVELT, JR.: We do offer a limited network actually. We are the only major plan in eastern Massachusetts that does, but two things, our restrictions on that, first of all, in just this market, employers who are the major purchasers of health coverage began about two decades ago to insist on totally comprehensive networks. So that is a market force -- if you are going to try to counter-market forces, you are going to need legislation and regulation.

But, secondly, the regulations of the Division of Insurance require a much higher degree of so-called adequacy of networks -- hospitals within a certain number of miles of every members than in most states.

So we not only have a consolidation situation, we have a regulatory structure that depresses competition.

MR. MICHAEL BAILIT: Okay, I want to zero in and make sure what I think you are saying -- I just want to be super clear on it.

It sounds like what you are saying is you can't negotiate lower increases in payment rates or no increases because otherwise, you are told at the negotiation table we won't be part of your network.

MR. JAMES ROOSEVELT, JR.: As the globe has documented, Tufts Health Plan put this to the test about ten years ago and came within days of being forced out of business.

MR. MICHAEL BAILIT: I want to follow on this topic. Bruce Bullin, a colleague, wrote on his new blog just recently about the insistence of purchasers and consumers on products that include every possible physician, the result of which has been the relentless increase in the price, not necessarily the use of services.

Phil, so I want to ask you, you sat on the other side of the negotiating table.

So are you essentially able in your negotiations with insurers to some degree to name your price because they have to have you in the network?

DOCTOR PHIL GAZIANO: No. Our network isn't big enough and we don't feel the need to.

We prefer to partner with hospitals, with the payers and we partner with Tufts and others and our specialists and the members and make it a choice.

We feel as was mentioned before that if you do put enough of the resources into the right infrastructure you can manage the care. We found in our 12 years that the predicted 20 percent of health care expenditure being wasted is actually accurate, and that when we reduced unnecessary testing and unnecessary procedures, that the health of our members got better and even their satisfaction got better so because of that we don't feel the need to say to the payers or to the state we need a higher price -- just as long as we have the global capitated budget and we put in the infrastructure ourselves that that worked out fine.

MR. MICHAEL BAILIT: Okay. Paul, I would like to follow up with you.

So here the market dynamic drives up price. I am interested in your perspective on the extent to which they also drive up costs.

Steve referenced a new health affairs piece that suggests that where there is market leverage not only do prices go up but costs go up I know that John Berto who is on MED PAC was here in the fall.

It gave him the opinion that lack of competition has related in higher prices that resulted in higher costs basis so a more extensive fiscal plant, equipment and higher wages.

To what extent has our lack of competition resulted in us developing a cost base that is particularly high?

MR. PAUL LEVY: I haven't seen that article that he referred to so I can't comment on that, but I think perhaps a way of getting at that is the following.

We know from the Attorney General's report that there is a wide variation in pricing between -- from the insurance companies among the provider groups, but by the way that is with respect to both global per capitated pricing as well as fee for service pricing.

So remember that when you get to your global budget and the need to deal with that variation in pricing.

So you would expect that if the

contrary were true to what you were saying that the institutions that get the higher prices would have significantly higher margins overtime.

In other words, their costs would be about the same but they would have more margin. My impression is that although the higher paid providers had a slightly higher margin, it is not so noticeably higher that it would indicate the best case.

In other words, it appears as though they have built into their cost structure the expectation of ever higher prices. So I would imagine that that is in fact the case.

I say that -- while I know that we, for example, at BIDMC are both the victim and the beneficiary of the current pricing regime.

As I look in the charts that have been submitted, it looks like we are about in the middle of maybe upper middle slightly. I wouldn't like to think that we set our budgets based on what we can get paid exclusively, but I imagine there is certainly an aspect of that.

We set earnings targets for ourselves each year based on the reimbursement rates we are expect to get. That in turn influences the degree of staffing, for example, the raises we give our employees and our capital expenditures and so on.

In essence, it creates an annual budget for us. We try to set a margin requirement that produces a sufficient return to replace capital in our facilities and so I guess it is just a truism that if you know you have more money coming in, you are likely to create a budget that uses the money that is coming in.

MR. MICHAEL BAILIT: I suggest if we want to not only slow down the cost but actually bring down the cost, there would have to be a rather painful way of bringing down the built-in cost base.

MR. PAUL LEVY: I think that that is one of the big issues that those providers that have been receiving a much higher reimbursement rates are really scared of because if there is state action to bring them down to the average or someone near the average, they have imbedded cost structure that cannot be sustained and the question of how you manage that transition, assuming you want to do that is going to be equally important to those institutions.

MR. MICHAEL BAILIT: Okay. So I want to move a little away now from market dynamics and price and talk about other aspects of delivery system performance because clearly our opportunities to reduce cost growth don't just lie in addressing the current market competition and how it works.

So, Don, I would like to ask you a question. In your written testimony you submitted you wrote that we need to reduce waste in the entire health care system by streamlining systems using lean techniques, reliability, science and other discipline matters.

I have heard hospital executives

from other parts of the country -- from Pittsburgh, from Wisconsin talk about their application of the Toyota production system or of lean processes.

Would haven't our hospitals uniformly implemented those systems?

DOCTOR DONALD GOLDMANN: Well, as I said, in a slightly offhand way, use whatever system you want to get reliable across the system.

I don't think there is anything magical about the lean methodology that isn't expressed by clearly stating what the reliability is all about.

Let's give an example. In order to achieve reliability across the system, a couple of things are necessary. One is a clear aim.

If we take the care of an individual with asthma or somebody with diabetes or somebody with comorbidities, what is the aim and what is the system that we need to build to achieve the aim.

And it turns out if you listen to

what Brett James has to say, most of these systems can be articulated in a way that you can actually draw.

I don't think you have to do a rapid improvement event or a value screen map to articulate that system. To be honest, it can done relatively easily and there will be clear high leverage components of that system which all need to be done reliably -- not 40 percent of the time or 60 percent of the time but in aggregate, they have to be done right almost all of the time and then you have to ask yourself, well, you know, what is the actual affordance or the help that individuals need across the continuum or within a hospital to get that done reliably and it turns out there are fairly simple ways to do this.

They need checklists, care pathways, bundles -- there are a whole variety of reliability techniques that can be deployed.

MR. MICHAEL BAILIT: I guess, my question is why didn't this happen.

DOCTOR DONALD GOLDMANN: I think to some extent, it is happening. This gets to the how that I tried to emphasize. You know, just setting the target and the expression we use a lot is prayer is not a hope -- I can't remember the expression -- but you can't just sum it up like of a genie out of a bottle and see what it is going to be. It does takes training. The training turns out to be not that arduous or difficult but you have to have the will to utilize these tools within the system.

I will bet that you guys do utilize these tools within your system of care.

They aren't pervasive. They aren't necessarily encouraged and the 10 percent of time it takes in a real workday to do this stuff is usually not budgeted for.

MR. MICHAEL BAILIT: So how do we make it pervasive? Because, you know, I am a little skeptical that it is pervasive in Massachusetts right now.

I mean I know I have heard the CEO of Cedar Care was caught and bragged about how he takes 25 million dollars a year of his system by doing lean.

But I don't know hear that, you know, uniformly out of the Commonwealth today. So what do we have to do to become more efficient?

DOCTOR DONALD GOLDMANN: Let'S not confound the savings that occur across the continuum in a system that is integrated and where costs actually follow the improvements in care.

So quality improvement doesn't save costs for a hospital if the current payment system exists.

You know, it is got to be societal costs we are talking about now and societal costs aren't reflected in anything that I could see in the current payment system.

So that is a confound issue.

You know, it turns out actually that most providers do want to get good outcomes and the processes of care that are required are fairly well known for many conditions.

It really, I think requires a clear vision commitment of leadership and the people that they have in the organization who are trained to do these relatively simple things.

That doesn't really get in your question. There is no magic bullet for this.

Currently I don't see throughout most organizations the leadership and commitment to that kind of thinking and it is certainly not supported by the current --

MR. MICHAEL BAILIT: So do we need financial incentive and we referred to advocacy for APOs and global payment -- is that what is needed to create the impetus to become more efficient.

DOCTOR DONALD GOLDMANN: Yes, I certainly think that that will be helpful but if I walk into Cincinnati Children's Hospital right now, and I ask you to show me evidence that they can prove the outcomes from the children -- she can pull from her briefcase literally 14 or 17 run charts showing consistent improvement all done by simple reliability systems redesign with some coaching, and I don't think she is telling me Cincinnati Children's Hospital has just saved a bundle of money or this is our economic driver.

She will say that on 17 conditions that effect children -- those that account for 80 percent of the care that they give, they can show sustained improvement using relatively straight forward reliability systems improvement.

So, yes, it is a big help to get the will but it isn't going to necessarily help with the execution.

MR. MICHAEL BAILIT: Paul?

MR. PAUL LEVY: I have to disagree with your assumption there, Michael.

MR. MICHAEL BAILIT: Okay.

MR. PAUL LEVY: Let's take the general application of lean principals of 6 sigma to other industries which by definition are on a fee for service basis whether it is automobiles or steel or whatever, you would see the same variation in the adoption of lean approaches in those industries as we would in the hospital.

Steve Spear writes about this. He talks about the anomalies in different industries where they have chosen to invest in lean process improvements and how those companies have come to make those decisions.

So it is not a pre-condition of investing in lean and those things to have global payments. As I said to you before --

MR. MICHAEL BAILIT: Okay, what are the barriers?

MR. PAUL LEVY: The barriers are the leadership of the organization and the commitment to doing it and the governance of those organizations and I would say in a market like Massachusetts, to your point before is if you are overpaying certain providers they have absolutely no incentive to address their cost structure because they are going to be more successful by spending more, their network will continue to grow, their referrals will continue to grow notwithstanding their cost of business.

So to the extent that we have a disparity in what people get paid for doing exactly the same work in this state it works against the goal we have stated. Whether that disparity is in the form of global payments or fee for service payments, the same result obtains.

MR. MICHAEL BAILIT: It sounds like it is just not disparity because you could have uniform payment at a high level and that wouldn't necessarily create a compelling business case to become lean, so it seems to me that what we are talking about is having some level of economic price pressure to motivate an organization to become more efficient.

MR. PAUL LEVY: Yes, and what that level is, of course, remains to be seen.

My suggestion is, well, let's start with the average rates that exist in the state as a place to start and see where that leads would be a way to go.

We know there are hospital physician groups that are underpaid relative to the value that they provide.

If you look at the chart over here, if I were Ellen Zane at Tufts Medical Center, I would be mighty upset that her rates are what they are given her case mix index relative to BIDMC and relative to other people. It is just not right. There is no societal basis for what she and her hospital are getting paid. It is contrary to the public interest.

MR. MICHAEL BAILIT: Okay, Barbra Rabson, I am going to ask you about transparency. You, Don, Jim and Paul have all pointed to transparency as a fundamental problem.

I want to clarify exactly why it is a problem. And is lack of transparency really causing high and increasing payment rates?

I mean it is clearly having some transparency gives cause for us to want to focus on the topic but is lack of transparency the driver of costs.

MS. BARBRA RABSON: No, no, I think the lack of -- the driver of costs is this misaligned incentives because if you are paid to do things that don't need to be done and then you do them and there is a lot of waste -- so that is the driver.

I think what transparency does is introduce accountability both on the quality and the cost side and so you are able to see for the first time, you know, the work at the A. G has showed transparency and competitive costs given similar levels of quality creates the question that Paul is talking about.

And so it raises the dialog from a policy perspective it is really important. From a perspective of consumers we have done a lot of work with consumers. We have been quite frustrated, in fact, with the lack of engagement with consumers about the accessing our information or using it to make decisions and part of the problem is that we are not given consumers what they want and because it is too hard to collect and so we give them what we have.

So a perfect example is we ran some focus groups in Worcester around a group of consumers about the measures that MHQP has on their website. So we showed them the mammogram testing -- how often do women get their recommended mammogram and so a woman looked at it and she said, okay, so what you are telling me is that Fallon Clinic, 95 percent of the time, women who were recommended for a mammogram get the mammogram here -- and we said, yes, and she said, well, I don't care about that. I get mine. So why are you telling me that, you know, a societal thing -- she understood from a public health perspective that mammograms were important but for her personally she wants to know if she goes to get a mammogram, she is going to be treated well and if she has bad results, she is going to get them immediately and that if she has to go through treatment that it is going to be done well and she will survive.

So part of the challenge around transparency and quality side is we don't yet have the right measures that resonate with consumers so we are expecting them to act on what we give them which is a start, you know, but there is a lot we need to do.

MR. MICHAEL BAILIT: So if we want to solve our cost problems arming consumers with information on cost and quality might be a worthwhile aim but it is not going to necessarily be a key tool for addressing costs.

MS. BARBRA RABSON: It is part of the puzzle.

I mean the thing is we have to engage consumers because we can't expect physicians to take care of health.

Consumers have a huge role -- patients have a huge role in taking a role in their health and if they don't engage, we won't get the outcomes we desire.

So there is a whole continuum in what we want consumers to engage in. First and foremost, in their own personal health and health care and their family and the way to sort of grow your awareness around that, is you know am I going to the right facility, am I seeing the right doctor who can take care of what is important to me and am I being treated the way I expect to be and there is all kinds of relationships and so forth.

The continuum is really key. No where in the country has this happened yet. MHQP participates in regional coalitions with other sister coalitions across the country and we are all grappling with it and, in fact, we have just got part of the Robert Lee Johnson funding of community addition that really focuses on consumer engagement and it will be part of that family to focus on this issue but it is one that is going to take sort of a like public health issues, a 360 approach in terms of how you deal with it.

MR. MICHAEL BAILIT: Okay, Don, do you want to respond?

DOCTOR DONALD GOLDMANN: You know, I don't know the ground rules here but I think you have made an extraordinary point.

When I talk about transparency, I was only talking about what things really cost. I was talking from an individual point of view.

There is a chasm between aggregate measures reported publicly and the individual patient family centered care people experience when they go somewhere.

I actually think that measurement has four conceivable purposes and I will tell you what they are.

The first is punishment of some sort or reward -- namely pay for performance.

And the second which is consumer choice -- we have very little evidence that aggregate measures effect consumer choice.

Third is improvement which, of course, is exactly what I think measurement ought to be used for 90 percent of the time.

And the fourth is research and those are the four ways in which measurement could be used and it is really important to think what the experience is that the patient and the family undergoes with respect to the time measures that you are asking to be transparent.

You are absolutely right when a patient goes in a clinic, if it is truly a patient family centered place, what they want and truly need will be discussed and done if they are not engaged, not mobilized, not aware, then you will have to rely on the aggregate average performance which is generally not high enough at least for my tastes.

MR. MICHAEL BAILIT: Jack, I would like to ask you a question now.

Steve Schoenbaum in his presentation shared some information that said that organization is enabler although not a guarantor of higher performance and I am interested in to what extent you think that the manner in which providers in the

Commonwealth are organized or not are contributing to our high costs and high cost growth and if there needs to be more organization, is it an organization of physicians or is it an organizations of physicians, hospitals and others perhaps.

DOCTOR JACK DUTZAR: Well, I am not sure I can comfortably respond to the first part of that question.

You know I am a longstanding believer in the aggregation of physicians especially in the context of multi-specialty group practices and for the reasons I talked about in my testimony.

It creates an opportunity for us to invest in a system of care that are the kinds of things that allows us to move the patients through their process of their health and health care experiences from hospital to their home and medical office.

We are in a position, for example, as a reasonably good sized multi-specialty group to invest in very sophisticated health information technology that allows us to connect with our patients not just in the context of the office visit, but in the context of internet access with them individually and all the rest.

We haven't seen the full payoff in terms of that level of aggregation and organization in terms of the cost reduction partly because of the initial investments are so high and the training and cultural changes are so daunting but we believe in the long run we ultimately will -- that the relationship between our group and our local hospital is recognized by both our hospital and us as being inadequate and not in good service to our patients.

And we are -- the leadership of both organizations is collectively committed to that.

Over the course of the long period of time I have been doing this, the hospital has always been the center of the health care universe except for patients -- most patients are not in hospitals and most patient's experience with their health care doesn't occur in that environment at least with any kind of regularity or frequency.

It is a key aspect and important element and I believe that the concepts of managed care, the concepts of capitation will drive a level of integration and organization and whether we call them accountable care organizations or not it is ultimately key.

The hospital -- the other issues that I would relate is over the years I was trying to understand what would reduce costs -- patients costs issues are often changed or driven up in the transitions, transitions between the medical office and the hospital and the hospital back to home and then surrounding -- and often patients fall through the cracks with inadequate information, inadequate follow up and once again in organized systems like ours, we can invest as some of the others that testified, we can invest in systems to help support our patients throughout those processes and do our jobs.

We are not doing the community as good a job today as I believe we can do -- but we do have that opportunity.

MR. MICHAEL BAILIT: Let me ask about some of the market implications of having more organized systems, whether they be health care organizations or the other name.

I know the special commission on health care payment has some concern that while there would be potentially great benefit in creating greater organization, that there might be some pricing locations -- in fact, the commission recommended that there be an oversight authority created specifically to monitor that regulatory power.

And I know that the Attorney General's office has expensed concern as well.

Is there a real threat that efficiency gained through tighter levels of integration and organization -- that would potentially result in savings would be given away because the decreased competition would result in inflated pricing.

DOCTOR JACK DUTZAR: I think size is relevant in that. I am not sure if the level of integration coordination is.

MR. MICHAEL BAILIT: Let's say that in Worcester County there is one accountable care organization, that the level of integration and consolidation became that big.

So under that scenario, could it be that whatever efficiencies are gained through that organization and maybe they are doing everything lean and eliminating waste but they can turnaround to Jim or any other payer and say, okay, we are the only ones in Worcester County so here is what you are going to pay us -- is there a potential that the savings that we obtain are going to be giving away on price.

DOCTOR JACK DUTZAR: Well, I guess the theoretical answer -- the short answer to that would be, yes, but that is never going to happen and what I do think is that there are opportunities for more integration among existing infrastructures. We have three basically reasonably organized systems in the central area directly around Worcester and even up in the north part of the county in Leominster there are small integrated medical group and hospital activities that do that do a darn good job even though they are our competitors.

MR. MICHAEL BAILIT: Can I ask you why you think it won't happen because this graph or this chart up here suggests that it happens today with hospitals, so why wouldn't it happen with accountable care organizations?

DOCTOR JACK DUTZAR: Well, I assume that both the Federal and the state level there would be opportunities for oversight at that level of aggregation and market account.

I mean that happens because of fee for service, the term there. If you set your pricing as the federal government does based on essentially a county rate and state rate and adjust it for severity, then it wouldn't matter how big my ACO is, the, you know, adjusted payments should not be based on, you know, whether I have a big ACO or not a big ACO and whether or not you have the title ACO, most of the components are, in effect, now in global capitation, H.M.O. type of networks.

The risk that the other thing to think about with regulation is you probably do want to ensure that networks aren't too small because if you have a very small network of physicians and they are not experienced in this type of care, then they can lose a lot of financial resources and go under the members they serve can be ill served, so you may want to have a minimum bar for some of these.

We have found that the -- that those that are in those networks are going to have to teach the others, but actually the transaction to more of the accountable care organizations will create expertise and systems that would actually keep

Massachusetts in the forefront of the nation.

MR. MICHAEL BAILIT: Okay, what I am hearing from both of you is that there would be a need for either the definition of some parameters for how global payment rates would be set and for some level of regulatory oversight to protect against that.

MR. JAMES ROOSEVELT, JR.: Michael, could I just comment on that?

MR. MICHAEL BAILIT: Sure.

MR. JAMES ROOSEVELT, JR.: Our experience with our Medicare advantage plan is that size makes a difference but there are various ways to compensate for size to achieve for success and integration.

So for example as Doctor Spivak has described -- I am using the last names because I am sitting between two Barbaras. As she has described, they are among the best well organized and have the best resources that they have acquired to manage and integrate, but we also have within our

Medicare preferred plan much smaller groups of physicians and we has a health plan provide many of the tools that MICIPA does on its own. I think MICIPA does it to a greater extent but smaller groups of physicians can be very successful if they have the tools to monitor overuse and underuse of care, if they have the guidelines.

And so I think it is a combination of size, of resources and tools that are used and of geographic dominance to get back to your question -- if an accountable care organization over a large metropolitan area is dominant, it has a different effect on the pricing systems.

MR. MICHAEL BAILIT: Okay. I want to go to Barbara, and I want to ask you a question, Barbara, on the topic of waste, so Phil talked about 20 percent.

There are some research estimates that suggest that 30 percent or more of all health care services that are delivered provide no benefit to the patient and, in fact, sometimes harm the patient and, in fact, just this month the American College of Radiology published a study. They looked at the use of C.T. scans and MRIs and found that 25 percent were inappropriate.

So I would like to ask you what are the most contributing reasons to overuse of services?

DOCTOR BARBARA SPIVAK: We think that there are several reasons why there is overuse not the least of which is the malpractice system that we have today which encourages physicians to do everything they can immediately to avoid the risk of being sued later on.

We also believe though that often physicians don't order the right test the first time because they don't really know what the right test is.

So I think one of the things we have done in our IPA is to encourage people to ask questions and when, for example, after physicians order an MRI have radiologists actually make sure that they have a history that says what the MRI is really looking for and if that MRI is not appropriate and is not the best test, they will actually call the physician and say we reviewed this -- we recommended that you do an ultrasound first and I think by trying to teach people to do the right thing first, you can really save and improve utilization.

Pharmacy is a huge example of waste because there are at least 10 drugs out there for every problem you want.

And many of them are generic and cheaper than some of the ones that have not yet reached that status, but the ones that the pharmacy companies go out to and give lunches for are the ones that doctors tend to prescribe.

So by having a pharmacy program at our IPA we have encouraged the use of generics and we have kept our trends, our cost trends and our PMPM costs down dramatically.

So I think by educating doctors and educating providers, we can really prevent a significant amount of waste.

I also think that one of the things that we have to realize as we are talking here is that patients have to understand that as well.

When a doctor is sitting in the office, it is the doctor/patient relationship that is primary and too often the health care system doesn't help patients to do the right thing.

So if you look at what we have done to try to control costs from the patient's point of view there has been tiering -- well, tiering doesn't do a whole lot -- if you are critically ill and you are seeing a tier 3 specialist because you have multiple sclerosis and your neurologist is tier, we have now taken our sickest patient and made them pay higher co-pays because they have to see a doctor more often.

Tiering hospitals haven't really moved patients because people really think that they are getting the best care by going to the more expensive hospitals.

And high deductibles don't do it because it really prevents patients from getting necessary care as often as it prevents them from getting unnecessary care.

So I think one of the other pieces that we have to address is aligning incentives not just for the providers, the hospital and the physicians, but we really have to find a way of engaging the patients so that they understand that we are providing better care not just less expensive care but that we are trying to provide higher quality better care.

MR. MICHAEL BAILIT: Okay.

ASST. ATTORNEY GENERAL LOIS JOHNSON: If I could follow up on that, one of the things you mentioned, Doctor Spivak, in terms of your success was that the integration took time and it took money and you also highlighted the importance of networks and just to follow up of what you were talking about of engaging the patient, can you talk about how you have used networks or encouraging patients to stay within your network as part of your strategy?

DOCTOR BARBARA SPIVAK: Well, our strategy has been -- we have a community hospital, Mount Auburn, which provides a huge rage of services from open heart surgery to neurosurgery to vascular surgery and our way of controlling costs, one of the ways has been to try to keep as much of the business that can be done and performed at our hospital with our specialists within our network.

And the way we have done that is by educating our primary care doctors what our own doctors can do.

So by being a small hospital, that has helped us because the doctors all know each other.

So when I have a patient who needs surgery, it is much more effective for me to be able to say that I know the vascular surgeon that I am sending you to, he is terrific and I am going to call him when you leave and make the referral.

I think that helps patients feel comfortable that their primary care doctor who presumably they are seeing me because they trust me also will trust the referrals.

I think that development of networks is going to be key for any future global capitation system that you develop because I can't control utilization costs when patients go outside of my hospital.

MR. MICHAEL BAILIT: I want to ask a couple of questions that have been submitted by the audience.

The first one, well, I will say thematically with the point that Barbara touched upon.

I guess, Jim, this would be for you -- resistance to limited networks by employers stems from the fact that there is not a great price differential between limited network products and other products.

Is the Tufts product price significantly lower or is it marketed adequately?

MR. JAMES ROOSEVELT, JR.: To

answer both parts of that question, the pricing difference -- although I don't have the exact numbers is approximately 25 percent -- so I think that that is a significant difference.

MR. MICHAEL BAILIT: Is that available to both large and small.

MR. JAMES ROOSEVELT, JR.: Well, that goes to the second part because is it marketed adequately.

In order to get provider participation, we had to -- to assure providers that it will be offered only to individuals and those small businesses who were eligible to purchase through the connector.

So it is not marketed to larger businesses.

Now I will tell you that for the roughly three years that we have had the limited network, I have tried to promote, to broker interest in it because that is what could bring a change -- demand could bring a change in those limitations -- never had any positive take up on that until last month.

Last month at our semiannual broker meeting, brokers were all over me -- why can't we sell the limited network to our groups.

And so I think that there is whether it is because of information or actually I think -- I think a lot has changed because of the general economic situation in the country.

When we did health care reform in 2006, the Massachusetts Associates of Health Plans commissioned a study that demonstrated there would be a two to four percent increase in premiums because of the merger of the small group and non-group markets -- two to four percent increase for small businesses even though there was a 20 to 25 percent decrease for individuals.

Everybody in the economy of 2006 said two to four percent -- who cares about that. Now that is a big issue. So I think we are entering a different period and indeed the participation level which is about 2,500 people in our limited network, for the last two years has caused an internal discussion in our plan -- why are we putting the resources into keeping this going and I have taken the position which since I get more votes has prevailed that we should hang in there, the market is going to come to realize that cost and quality can be combined as positive factors.

MR. MICHAEL BAILIT: Paul.

MR. PAUL LEVY: I think one of the reasons Jim and others had trouble selling limited networks is because those business subscribers who are acting on behalf of their employees, find that their employees believe that the reputation of the hospitals in the geographic area and I think it is very sad that that reputation has no basis in fact for the reasons Barbra Rabson was talking about before. We do not have sufficient transparency of clinical outcomes to be able to say to potential business subscribers and their employees is the reason we have not included hospital X, Y and Z is because their results are no better or worse and because they are 15, 20 percent more expensive.

In the absence of that data and I am not saying that data would be used by consumers in making a choice day to day would be used by subscribers in making a choice of an insurance product does not exist in the public domain.

The data that Art put out there the CMS data and so on are two years old and they are based on administrative data and they are not really useful in a marketing sense I would guess although Jim can tell us better than that and I think it is a legitimate function of the state government to make that data more accessible.

In my conversations with my colleagues around the Boston area and my attempt to have them agree to publish this kind of data jointly, that has been not acceptable on the part of -- and I think it is because they fundamentally understand that if the data were made available, the emperor would have no clothes and it would be seen that there is essentially not a big difference among the quality of service provided to the public by the major hospitals in the Boston metropolitan area.

MR. MICHAEL BAILIT: Thank you, both. I think the next one is for you, Jack.

While no one can argue that integration is likely a good thing, the reality is that our two oldest largest integrated systems in Massachusetts including Fallon have the highest total medical expenses in their geography, when could we expect to harvest savings from those models?

DOCTOR JACK DUTZAR: Well, I am not sure I accept the premise of that question nor do I fully understand the concept of it. Maybe you could help me with that.

MR. MICHAEL BAILIT: Well, I know the factual basis for the highest total medical expenses, but there seems to be a sense that where we have integration we are not achieving the efficiencies or savings that we might.

DOCTOR JACK DUTZAR: Well, when this whole process started, I thought it was going to be extraordinarily interesting to us because we don't know where we come relative to other care delivery systems in terms of their total costs of care.

I actually tried to get the folks to share with me which of the bars we represented on the list and they were unwilling to do so quite appropriately.

What I would tell you is that we have indirect evidence that the statement made by the question is inaccurate.

The indirect evidence is that all four of the major health plans in the Commonwealth that are visibly actively interested in developing their own network product with us, the existing narrow network product we offer has been meeting the market by 10 to 20 percent and brought a range of the commercial market in central

Massachusetts for many years, we deliver $20.00 to 25 to $30.00 per member per month lower costs for pharmaceuticals than the average for the Commonwealth, and so I am not sure -- I mean I just don't except the premise.

ASST. ATTORNEY GENERAL LOIS JOHNSON: For clarification and for your --

DOCTOR JACK DUTZAR: -- my curiosity?

ASST. ATTORNEY GENERAL LOIS JOHNSON: In the Attorney General'S full report we do have some charts that track the total medical expenses of large physician groups and we identify which provides are globally paid or paid some risk based contract versus fee for service and you can see that the method of payment bears no relation to the level of TME and that some lower paid providers do significantly have significantly higher TME than their fees for service.

DOCTOR JACK DUTZAR: I read that but for me the complexity never goes away.

Because one of our major payers or our primary payer at some point, we have risk adjusted data that suggested our commercial enrollees are about 2.0.

So we are talking about absolutely dollars in a relative --

ASST. ATTORNEY GENERAL LOIS JOHNSON: This is risk adjustment.

DOCTOR JACK DUTZAR: Some of that has been uncertain whether it is risk adjustment or not.

When we looked at all of the data that we got back and information in the possess, we were very interested in it and ultimately, I don't know how to reconcile the fact that the payers are interested in working with us -- more because from their perspective we are supposed to -- we appear to be delivering both on premiums and total cost of care and the data that is presented, I just don't have a way to do that.

MR. MICHAEL BAILIT: Phil --

DOCTOR PHIL GAZIANO: We have information that 80 percent of the members that are network and/or physician group care fee for service and 20 percent are global capitation.

Even in our network the 20 percent in global capitation for seniors do use 20 percent less and have higher quality of scores for dollars because of that integration.

Now the 20 percent savings -- part of that has to go back to support those services and so it is not all profit.

With our commercial we were surprised to find that before we started global cap that the same group of patients we had a cost inflation above the state and county average of 8 percent and as soon as we started capitation on the same patient, we had a medical inflation rate total dollar of 1 percent -- same severity, same number and entire quality scores.

MR. MICHAEL BAILIT: I want to introduce a new question for both Phil and Jack, and that is regarding re-hospitalizations and E.R. visits, both commonly looked at as opportunities to improve both quality and reduce costs.

In Massachusetts for the commercially insured population about 5 percent of hospital costs would be admissions. For the Medicare population, it is more than double that.

And we know that a high percentage of ER visits are potentially avoidable.

Why haven't we been able to solve those problems? We have known about them for some time but we continue to have pretty high rates of both?

DOCTOR PHIL GAZIANO: Again the problem is, we learned six years ago that if you have an integrated disease management problem, you can prevent admissions but under fee for service nobody pays for it. Under global capitation it is paid for.

We just got the date on our admission rate where the state average for seniors is a little over 20,000 per year and, in fact, with Tufts, our partner, the goal was below 10 and our group came in at

9.8. We were one of the only ones under 10.

We got the readmission rate down because of our integrated disease management program. We also were is able to track, you know, reduced overall hospital day and admissions and dollars.

Before we started our disease management program just as with any medication population the top 3 percent used 50 percent of the dollars.

As soon as we started that within two quarters it dropped to 42 percent and it has remained there and that, for our network, has saved a few million dollars.

We also found that the satisfaction of those sickest of the sick, those 300 that we have on our disease management program goes way up. They are happy with the extra phone calls, doctor visits, home visits that we put in to do that and, in fact, when one of them heard that she was going to have to give up her Nurse Nancy coming into the home, she quickly paid up the premium. So they are finding it a benefit.

MR. JAMES ROOSEVELT, JR.: We appreciated that too.

MR. MICHAEL BAILIT: Barbara Spivak --

DOCTOR BARBARA SPIVAK: I would like to agree with that. We have found that making sure that patients have a visit with their primary care doctor anywhere from 3 to 7 days after discharge from a facility is a key factor.

We actually monitor the number of primary care visits per year and when groups fall below a certain amount, we actually meet with them and encourage them to see their patients more.

We have found a direct correlation between when groups fall below a certain amount, we actually meet with them and encourage them to see their patients more.

We found a direct correlation between the groups that see their patients more in the office have a lower based hospital rate and a lower re-admission rate and a lower ER use.

So just the fact that we are encouraging with primary care to be actively involved is a major effort.

But it also clearly decreases costs.

On top of that I think like Hampden County all of our high risk patients are in case management programs where the case managers call and make sure that patients keep their appointments and make sure they are taking their meds.

Every patient that is discharged gets a call from the case manager within again depending on the severity, 24 hours or 72 hours after discharge to make sure they have their meds and the meds are correct. We have a program where we send either a nurse practitioner, a nurse or even a pharmacist into the home to make sure that meds are correct and being taken correctly. So meds that should be taken without food are taken without food and not taken together with others, etc.

All of that I think costs a great

deal to maintain those systems. The patients are clearly feeling better about the care they receive. They are getting better care and at the end of the day hopefully the costs to the system are less.

MR. MICHAEL BAILIT: Barbara, what are the greatest barriers that you face to reducing health care costs and improving quality?

DOCTOR BARBARA SPIVAK: The greatest barriers we have are that the fee for service world doesn't pay for us to do what we need to do.

When we have patients who are on their own, who are on straight Medicare, it is much harder to provide them with the services that they need.

The rules of the visiting nurse are that they are happy to go when the person is homebound, but as soon as the person can get walking and get out of the house, they don't really want to go in any more.

Now that works for many patients who drive, but for the patient who is over

80 and has poor vision and no family and can't get out of the house any more, it limits what we can do.

On the Tufts Medicare Preferred Product, for example, our physicians take the money that we get and we put it back into services so that our patients can stay at home safely.

MR. MICHAEL BAILIT: What about for your capitated populations that you serve, what are the biggest barriers there?

DOCTOR BARBARA SPIVAK: I think that the biggest barriers that we have are that physicians honestly feel overworked and underpaid particularly in an environment like ours where we live in and practice in Cambridge, Somerville, Watertown, Belmont, Massachusetts where some of the networks that we are talking about that are higher paid are the people who live next door to our own doctors and the nurses.

And we have patients I think who are not invested in working with us. It is very hard to get to be held accountable to getting a diabetic hemoglobin A1C down when they are smoking and overweight and not exercising.

There are financial implications for patients with high deductibles who need tests who don't want to do them.

I think people have heard me talk about this a hundred times. Charging the patient $250.00 co-pay for a colonoscopy does not encourage that patient to get that colonoscopy.

DOCTOR DONALD GOLDMANN: You are hearing something really important here.

I don't know how many people come to this hearing because you are patients, you are here because you are patients -- are there a lot of those.

(No affirmative response from the Audience.)

DOCTOR DONALD GOLDMANN: But we are not -- what you are hearing is you are hearing a change in the emphasis of the discussion even though you are asking questions about payment and network, what you heard especially from Barbara just then but also from others is the story of a typical patient, a specific patient and you will notice she didn't use the word doctor, doctor, doctor. She talked about nurses and people who go in the home and other supports and pharmacists and she talked about the patient and what their trajectory is through that system.

She did talk a little bit about doctors working too hard but basically it was the story of the patient and I think you can even design the policy, the payment system for quality and cost from a theoretical school of public health way or you can listen to some of these stories and figure out what would have been the lowest cost, most efficient, most reliable path that that patient could have followed to not get back into the hospital or into the Emergency Department.

We have actually been telling stories of some patients who come to the ED and it turns out that what they are telling us is not a lot to do with the primary care doctor or any of that. It is I didn't have transportation. I was 80 years old and nobody could drive me. I didn't have the care.

Until you start really understanding the stories, you can't figure out the system that will address them in the most lean way.

The other thing you mentioned was the coloscopy and the nurse going into the unit. There is disruption here.

I said in my testimony that we don't pay enough attention to train people in the community who are not nurse practitioners or doctors who can do those services. Simply with colonoscopy, the disruption there is that my G.I. guy who I love above all of the people in the world who does my colonoscopy -- I would actually rather have it done by a nurse who is properly trained can probably do it for the half price with him standing by.

I can tell you more about my shoulder which can tell you more about the health care system in Massachusetts than all of the discussion about policy and payment we have had but I won't because we don't have the time.

MR. MICHAEL BAILIT: I have one last question to ask of you.

In Steve Schoenbaum's earlier presentation he spent sometime talking about primary care in the medical home and this topic has not come up in our discussion today.

So I would be interested in asking you as a group -- you can raise your hand if you are interested in the topic -- to what extent is primary care clinician supply -- primary care clinician supply and a lack of medical homeness an issue that influences health care costs?

DOCTOR JACK DUTZAR: I was actually anxious to respond previously.

We have also built disease management and other systems to care for our patients and I think it has had a positive impact as the others describe.

One of the things we have been looking at is emergency room utilization and we have actually done some correlations with the emergency rooms around various of our practices that are either over subscribed or for want of a better term normally subscribed. Primary care physicians with a normal population versus people that are just varied and overpopulation and the correlation is very strong with excessive E.R. utilization.

So one of the things that we would say has been a major challenge for us is building our primarily care base.

We believe that we could grow dramatically and successfully if we have access to more high quality primary care physicians and that we could lower our costs dramatically associated with both the more comprehensive ongoing care of chronic disease but also in terms of things like avoidance of unnecessary and inappropriate hospital utilization.

We are also just if I can backtrack

on an answer, undergoing a major lean transformation and the commitment and the investment of that is enormous. We are doing it in concert with or in commitment of developing the patient centered medical home that is built with the focus on the patient and the elimination of waste for the patient as well as for the system itself.

These are all things that we can demonstrate in at least one of our major facilities but it is a long and very challenging and difficult process.

If we have a single overriding challenge, it is to get the kind of physicians and the primary care that we need to achieve our goals.

MR. MICHAEL BAILIT: Okay. Thanks. Let me --

DOCTOR BARBARA SPIVAK: -- I think in the primary care, I can't speak to the primary care access in the state but I do think that we need to work very hard to make it that our primary care doctors are actually doing real medical work and not the kinds of paper work that is required of them today, and we have to redesign the system so that the amount of time a primary care doctor spends on paper work is not 20 to 30 percent of their day but 2 percent of their day and that ancillary people are doing it and doing it well and I think that the system has to realize that primary care doctors are in short supply, the stream coming from medical schools is not going into primary care, and the piece that makes primary care valuable is that you have the same person talking to the patient over the course of years, not moving from one practice to another every couple of years, and we have to build a practice style that encourages consistency but really allows a doctor to take care of patients.

MR. JAMES ROOSEVELT, JR.:

Michael, I just have to add to that -- there is a cure for the primary care doctor shortage and so in terms of existing primary care doctors having primarily care doctors doing what they should be doing both clinically and administratively is important. But in terms of future primary care doctors, when we had an extreme nursing shortage in this country, we doubled the pay of nurses. We may have some misallocation now but we no longer have an extreme nursing shortage.

Tufts Medicare Preferred Primary Care doctors under the global payment system are better than 300 percent of what they would get paid for traditional fee for service Medicare. That makes it worthwhile for them to do the right thing.

I think if we go system wide with that, I think you will see a difference in what students coming out of medical school choose to do.

MR. MICHAEL BAILIT: So let me wrap things up. You have been a great panel, very forthcoming.

Some of the things that I picked up first there seemed to be broad agreement about the ills of our current market dynamics and that is driving both increased prices and also increased costs in the system.

And there is some, I think, general agreement that government has some role to play in providing some protection against variation that has occurred in the marketplace. There is an interest among at least some of you, a strong interest in broader use of global payments but not uniform, and in conjunction with that better coordination and integration of the delivery systems.

What I also heard is that achieving some improvements aren't simply going to require effective leadership. That to some degree the only ways organizations get better is if the leaders drive that improvement in performance.

And the last message that I take away is that a number of you feel that we have got some examples in place within the Commonwealth today of processes and arrangements that seem to be working to some degree, and that our goal of achieving a more effective and efficient health care delivery system is something that is achievable.

So with that, again, I want to thank all of you for your time.

(Whereupon at 12:29 p.m., the lunch recess was taken.)

C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS
Norfolk, ss.

I, Maureen Nashawaty, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that the foregoing transcript taken on Thursday, March 18, 2010, is true and accurate to the best of my knowledge, skill and ability.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 11th day of April, 2010.

____
Maureen R. Nashawaty
Registered Professional Reporter

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Massachusetts Health Care Cost Trends
Final Report

Appendix C.5d

Health Care Cost Trends Public Hearings

Transcript for Afternoon Session
Thursday, March 18, 2010

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COMMONWEALTH OF MASSACHUSETTS
DIVISION OF HEALTH CARE FINANCE AND POLICY

ANNUAL PUBLIC HEARING UNDER M.G.L. c.118G, SECTION 6 1/2 HEALTH CARE PROVIDER AND PAYER COSTS AND COST TRENDS

PANEL:

David Morales, Commissioner, Department of Health Care Finance and Policy
Lois Johnson, Office of the Attorney General

HELD AT:

University Club, 11th Floor
Joseph P. Healey Library
University of Massachusetts, Boston
100 Morrissey Boulevard
Boston, Massachusetts 02125
On Thursday, March 18, 2010

Afternoon Session Commencing at 1:00 p.m.

COPLEY COURT REPORTING
The Mercantile Building
71 Commercial Street, Suite 700
Boston, Massachusetts 02109
(617) 423-5841

I N D E X

PROCEEDINGS

COMMISSIONER MORALES: Thank you again for coming. I hoped you enjoyed lunch. We've had a really, really good and robust discussion this morning, and I expect this afternoon's will also be robust. I'm looking forward to it. But now it's really an honor and pleasure to introduce Professor Stuart Altman who is going to head up our next presentation. Professor.

MODERATOR ALTMAN: Thank you. Well, I have a real honor today to introduce my good friend Paul Ginsburg. And I have a great opportunity because after he makes his presentations, I can sort of either feed him or push him so that he says everything to reinforce what I'm going to say tomorrow.

(Stenographer interrupts.)

MODERATOR ALTMAN: I'm sorry, we have to pledge allegiance.

(Speakers Sworn.)

MODERATOR ALTMAN: Well, in a way, I mean, I'm the most conflicted person you're going to have, so I'm purely objective. I sit on the Tufts Health Board. I'm on the board of several insurance companies outside of Massachusetts. I used to be on the Beth Israel board. But most importantly, I'm falling apart, and I'm a patient.

So other than that, I'm purely objective. So with that said, I think I can be pretty objective. So with that said, again, let me say how really pleased I am to moderate. I just want to -- I don't know if all of you know this, but I think if I was to single out one person over the last decade who has done more to educate us on what is going on in this country, it would be Paul.

I mean, I can say that. I wish it was me, but it is Paul because of what he's done in his capacity as the President of the Center for Studying Health System Change. Paul's organization under his leadership, I've gone around the country, including here in Massachusetts, trying to understand the underlying forces that are generating our health care system here, in California and in many other markets around the country.

And he publishes often, and he is as objective and balanced because he generally agrees with me, I say that, as anybody that I know. We are very fortunate that he has agreed in his very busy schedule to come and join us here in Massachusetts.

Paul is not totally unknown to us. He graduated and has a Ph.D. in economics from Harvard, part of that core of really first-rate economists that were trained in the late 1960's, early 1970's. Paul went on from that, taught for awhile at Duke and Michigan State, but gained his real expertise working in Washington.

He was with the Congressional Budget Office in a senior capacity and then served as the director of the organization that was responsible for advising Congress and the Administration on the establishment and the operations of the physician payment system.

I was on the hospital side. The two of us worked very closely together. Many of you know the organization today as MedPAC, but -- in the eighties, we were two separate organizations.

Then I think Paul, for awhile, you actually went on into the transition into MedPAC, right?

SPEAKER GINSBURG: No, I left.

MODERATOR ALTMAN: You left. Both of us left, right. So anyway, the important thing here is that Paul has been a key player, understander, analyst of our health care system for almost 40 years. So it is a great pleasure for me to introduce Paul and let him give you the benefit of what he has learned over these four decades. Thank you.

SPEAKER GINSBURG: Thanks. It's always a pleasure to be introduced by someone who really nose you. You did a great job, Stuart. I don't know if I can turn this around.

Anyway, as Stuart mentioned, one of the things I do in my job is periodically visit twelve randomly-selected metropolitan areas, same each time, to find out what's going on in the delivery, financing organization of health care. And Boston has been one of them from the beginning which was 1996.

Actually, I was here last week and met some of you because my team was doing it's seventh round of site visits in Boston. So to begin with, you are blessed in Massachusetts by having some terrific policy analysts in all areas. And one of the results I think is that you have some very valuable data that the Division of Health Care Finance and Policy and the Attorney General has produced.

It's richer than national data. It shows that price paid to providers is a key factor in the recent trend in spending here, butt hat utilization contributes as well. And it shows the large variation in prices across providers which is something that it's rare to have data that can do that, and it appears to reflect in part at least the market leverage of different providers.

So let me start at the beginning in saying what drives provider prices? And basically, there are two things. There's a demand side and a supply side. Now, on the demand side, I would summarize it as the absence of demand side restraints, the absence of the restraints that we have in much of the rest of the economy because this is health care. And we use third-party payment extensively.

So those who need the care are the

patients, you know, tend not to have much constraining them as far as what they would like. We see all over the country, and I suspect is the case in Massachusetts too, that purchasers who were employers and some individuals demand insurance products with broad choice of providers.

They won't tolerate products that omit some of the notable hospitals in a community. When insurers have offered narrower networks, they don't find a lot of interest. Some of them are viable enough to be continued, but none of them draw a lot of enrollees.

In every community, there are must-have providers, hospitals and sometimes large medical groups that if they are not in the network, you know, consumers look at that and say, *What a cruddy network. I'm not going to buy that product.*

So this, as you can imagine, undermines insurers' ability to negotiate prices effectively with providers if all of your customers want to make sure that those providers are in their network.

Also what I find is that the benefit structures in insurance provide few patient incentives to choose low-priced providers. For example, this little use of tiering for hospital or physician services the way there is for prescription drugs, and people now are used to prescription drug tiering where you have generics where you pay the least, and then you have preferred brand names. And then you have other brand names, and there's a difference. People accept that, but very little use of that for hospital/physician services.

Here in Massachusetts, the General Insurance Commission has been a pioneer in this approach. I can't say that there have been a lot that have followed what it's pioneered. And on our visit last week, we heard of what seems to me to be a promising initiative by Massachusetts Blue Cross Blue Shield to, in a sense, have significant difference in the hospital deductible for their preferred versus their other hospitals.

Now, supply side issues are important also in driving prices. The degree of excess capacity in a market is certainly important. I recently published a study based on interviews in California which a number of you I think saw in Health Affairs about two or three weeks ago.

And in California, you had a situation of over a decade going from a situation of very extensive excess capacity for both hospitals and physicians to a situation of very tight capacity. And that really showed up in the leverage that providers have to gain higher prices.

Obviously, the degree of provider consolidation is a factor. And also, something that is a recent, rapidly-developing trend nationwide is the extent to which hospitals are employing or aligning with physicians in different ways so that hospitals can negotiate the payment rates for the physicians, at least that they employ.

Because what we find is that physicians in small practices are the one part of the provider community that has very little leverage with providers. In many areas, their payment rates are no higher than Medicare payment rates. However, if you have a hospital negotiating physician payment rates, they can be much higher.

Now, I mentioned that there is a recent national trend of growing provider leverage. I think trends on the supply side factors are behind this. I mentioned before, the Greater Hospital Employment of Physicians, consolidation has increased. Capacity is probably market-by-market. It's increased in some areas, not in others which have experienced building booms.

And if we distinguish between having leverage and using leverage, this is where the payment rates from the public payers, Medicare and Medicaid, come in. Because you could have a situation where the hospital could have pushed for a higher rate; but it had a goal for its margin, and that's what it was.

Then it experiences Medicaid rate cuts, and where can it turn? It can ask the private insurers to pay more. It can't get more from Medicaid. It can't get more from Medicare.

MedPAC, that's the Medicare Payment Advisory Commission which is what Stuart was referring to with the merger of the two commissions that we led. They came back with an analysis of Medicare margins. And in fact, whereas this was in MedPAC reports in early 2009, looking at my e-mail, it just came out, another version of that, in Health Affairs Today.

Basically, the bottom line is that the fixed payment rates that Medicare has are not constraining costs at strong hospitals, that they basically find that hospitals that are very powerful are in a position to lose money on Medicare because their costs are too high and just make it up in their charges to private insurers.

Now, how do we address rising prices? And I want to point out that, you know, there are market and regulatory approaches. And you know, my sense of the history of health policy in the last few decades in the United States is vigorous arguments about whether the market is going to work or whether it won't work, and we should regulate instead.

And my sense is that we've come out of that argument with a comfortable solution temporarily of doing neither. I don't think we push market forces or regulation very strong in this country. And the point I want to make when it comes to provider payments is that these approaches are not mutually exclusive.

They're actually very closely related and tied at the hip in ways I will sketch out. In fact, you know, I think if you incorporate market forces into regulation, it works better. You won't have the degree of conflicts between consumers saying, *Why can't I have this,* when they don't have to make any choices as far as is it worth their money to do that?

So what does the market approach look like? I would say the market approach to buying health care in the United States is different types of insurance benefits structures, benefits structures that include incentives to choose less expensive providers over others.

So an example would be if the benefit structure varies the hospital copay or the hospital deductible according to which provider is chosen. And the ultimate design, and I don't expect insurers to go this far, at least in the near term, is what economists call reference pricing.

Reference pricing really just means you identify who is the high-quality, low-cost provider. And then your benefits structure says if you want to go to a more expensive provider, you pay the difference.

Now, such benefit structures, as I mentioned, are pretty rare. Think about consumer-driven or consumer-directed health care, which in some parts of the country are fairly popular. My site visit suggests not so in Massachusetts. But you know, the irony is that CDHP designs have very little in the way of incentives to choose lower cost providers despite all the rhetoric.

And it's just some concrete things, because if someone has a policy with a $2,000 deductible and they need to be hospitalized, well, that deductible will be exceeded almost automatically no matter where they go. And the result will be that they pay the same no matter what hospital they go to. So they don't have incentives.

You know, there are some incentives so that if someone is told they need an MRI, they can probably save some money with a large deductible if they go to the freestanding imaging center instead of going to the hospital outpatient department because they tend to have lower prices.

For one thing, the tax treatments of health insurance blunts incentives for such benefit design in the sense, you know, if the tax system is subsidizing your health insurance, which it does for everyone who gets health insurance through employment or through their own businesses, you know, why should we take this extra hassle when we can do that?

And finally, tiered networks are a type of a benefit structure, but they have been limited by data to do a good job in classifying providers into a preferred or not preferred network and by hospital resistance. And there are lots of anecdotes throughout the country of the most important hospitals saying we will be in the preferred tier, or we will not be in your network.

Now, I want to talk about the role of transparency in, price transparency in particular in market approaches. And the point I want to make is that without the right benefit structure, without the right price information that's meaningful to the consumer, price transparency can actually be harmful. It's unlikely to do any good.

And under the situation of universal insurance coverage which Massachusetts, of course, is very, very close to, I would say the insurer is the ideal data source for consumers because the insurer is in a position to focus on what is the difference in what it will cost you, the enrollee, with our plan by going to different providers?

So that's the information patients should want, the information patients could do something with. But it's only relevant in plans that choose the low-cost providers. You know, there's some concern that in plans where you don't have such incentives where it will cost you the same to go anywhere, why not go to the highest priced provider? You know, maybe they're better. So it is an example where a type of transparency potentially can do harm.

Now, if the government is to post the prices that have been negotiated between insurers and providers, the impact of that is unpredictable. And there are two possibilities. One, which I have seen in Massachusetts in the years that I've been studying with, is that transparency can constrain dominant providers through public pressure, in a sense just the criticism and the potential avenues for policymakers to punish providers who they think their prices are high. This certainly might be constraining it.

But there are also lots of situations where when competitors know each other's prices, that can lead to higher prices. And this has been documented extensively in other industries that where you have concentration, you know, a small number of sellers, when you have price transparency, prices go up.

There's a fascinating study in Denmark of where the government was concerned about Ready Mix concrete prices, and it posted those prices on the Web; and the prices immediately went up.

And here's why. It's because if you can cut your pricing secrets, you might get business away from your competitors. But if all of your competitors will know it instantly, you won't get business away from them. They will match it. So you won't do it in the first place.

So price transparency can be dangerous if not used properly. And I'm saying that the key thing for the potential upside of transparency is patients, consumers making decisions where the price to them is going to vary depending on where they go.

Now, let me talk about the regulatory approach, and this would be rate setting applicable to private payers. This does address the provider leverage issue. And also, it offers the potential to lead in the reform of provider payment methods. So in a sense, it can set methods that all payers can use.

And also, when I mentioned the combining of regulatory market, there still would be an opportunity within this regulatory approach for patient incentives to address the remaining provider price differences. In an all payer rate setting system, say for hospital care, hospitals will not all have the same regulated prices. There will be differences.

If consumers have incentives to favor the lower-priced hospitals, that can actually amplify the results of the regulation, perhaps make it easier to pull off.

Now, provider rate setting is quite challenging to do well. For one thing, there's a high degree of sophistication needed. For example, current contracting between health plans and providers can be very subtle.

There are many examples that I've run into where a physician group will negotiate a fee-for-service agreement with an insurer but bring data to the table saying, you know, look, if you look at the patients who go to me, their use of the emergency room is lower than the norm. In fact, their overall utilization is lower, so give me higher rates. So there's a lot of complexity in arrangements that a rate setting initiative needs to understand.

The governance structure of rate setting is critical. You know, Maryland, which has the one remaining significant process to set hospital rates, is done by an independent commission. And the independence of that commission in my view is a key factor in its long-term success.

I think the final thing I want to say is that you're unlikely to achieve large short-term gains in an industry such as in Massachusetts with very low operating margins.

Now, provider payment reform is very important because service volume is a key component of spending trends. And there's a need for broader payment units covering multiple providers. Basically, we need more meaningful units to price.

And I think this is the key to the success of both market and regulatory approaches. They need a better payment unit. And Massachusetts clearly is on the path towards developing global payments to address this.

And there can be a range of large and small steps to reform the provider payment methods. We're seeing new versions of capitation. Here in Massachusetts, there's the alternative quality contract from Blue Cross Blue Shield, a lot of discussion at the federal level about accountable care organizations.

There are opportunities to have per episode payment for selected episodes. Payment to medical homes, you know, a lot of people focus on the delivery system side of medical homes; but there's a payment side which I would call partial capitation. For patients with chronic disease, there's a capitated payment to the medical home.

Simple things like incorporating post acute care into hospital payment so that the hospital's responsible for rehab; and even down to the nitty-gritty level of incentives to reduce hospital admissions.

Maybe I better to skip this. Let me turn to my paper. Sorry about that.

(Pause.)

SPEAKER GINSBURG: I mentioned I was in Boston last week. And some of what I came away with on the interviews was that, I would say the theme of our visit in our upcoming report is going to be controlling costs. Everybody was talking about that. And Boston providers are anticipating greater accountability for spending as well as for quality.

And their efforts to increase efficiency are already underway. And we heard a lot of encouraging reports about the alternative quality contracts spurring changes in providers.

Who's going to take the lead in provider payment reform? And there are a number of possibilities. Certainly, we're seeing around the country and in Massachusetts significant private payer experimentation with different methods. There is the potential, and it's expected under health care reform, if in fact it should pass at the federal level, then Medicare will do substantial reform in its methods, and it will be leading the entire system.

Then there's the potential for states to develop and prescribe payment methods as Massachusetts is thinking about and using a Medicare waiver to bring Medicare into their system. And finally, should there be an all-payer rate setting system, that could lead payment reform.

So in conclusion, a great deal is at stake in slowing spending trends, and we should be focusing on both price and quantity or utilization because whereas in recent years, price has been more of a factor, I don't have confidence that that will continue. And the volume of health services is, has been our long-term factor and I'm sure will continue to be as well.

And I believe that reforming provider payment methods is the key to a substantial bending of the curve. And we want to get you to think in terms of ways to combine market and regulatory elements rather than just argue over which one we should do and the other one is awful. Thanks.

MODERATOR ALTMAN: Thank you very much. So let me press you a little bit, Paul, on a couple of things to see, A., if I understand it; and B., if this could help.

First, let me simplify for a minute and differentiate between the possible argument that said what we heard at the last panel, and I think you said it as well, is one of the leading causes of increased spending, increased costs have been price increases over the last decade and that most of those price increases have come from the increased power of providers, particularly hospital systems, the consolidation and changing market structure and the like.

So we face now two distinct options, which I think you've done a good job of trying to bring them together. But let me keep them separate for a minute. One is to essentially try to force the market to work better in two ways.

One, and let me see if I got this right, and please correct me if I don't. One is to reduce the market power of the providers possibly by making them smaller and breaking up their power base. And two is by making information available to the -- and in doing that, you will really increase the power of the payers.

And two, is to bring in, and these aren't inconsistent, the consumer more by more transparency of information on higher, but you've cautioned us in a lot of ways that that really has a downside. So that's one side. And on the other side is provider rate setting through some form of regulatory structure.

But I want to focus now on changing the payment system independent of changing the delivery system. So first of all, let me ask you if I got that part right?

SPEAKER GINSBURG: Yes. I would say -- well, you were summarizing the morning panel, and I wasn't here.

MODERATOR ALTMAN: I'm trying to put it in your context as well.

SPEAKER GINSBURG: Sure. The key thing, as I was saying, that transparency for consumers isn't worth anything until they have incentives.

MODERATOR ALTMAN: All right. Now, here's the issue, and it's the issue that I have, and it's the issue I think you've brought up, and I want to reinforce it. If we simply broke up the power base or if we did transparency, or if we did provider rate setting on the existing delivery system, how would you feel about that?

SPEAKER GINSBURG: I think that would be very limited as to what it can accomplish because our ultimate long-term problem is that we use health services very inefficiently in a sense in this country when we have a new technology, we tend to overuse it.

We use it -- for example, there was a

study that, I think a number of studies have come out that talked about aggressive treatments of cardiovascular conditions. Someone who has high cholesterol who has some bad scores but is perfectly, feels perfectly healthy, intervention with angioplasty and stents doesn't improve their life. It doesn't have positive outcomes.

My sense is that we do those things more than in other systems. And I think that's one of the real challenges. Basically, it's just overuse of health services or use of a lot of low-value health services and our fee-for-service payment system where the delivery system as the incentives to drive volume works against that. So we really do need a much profound change in the way we pay providers.

MODERATOR ALTMAN: And that's it. Let me build on that. I think you've made that point, but let me home it in. What I heard you say, and obviously what we talked about this morning, is the idea that we need to change the payment system. And you call it a broader units of payment. Whether we call them capitation, global payments, bundled payments, payments for value, they come under different names, and they have slightly different meanings.

But at the end, is it the payment system that's important; or is it that the payment system will drive delivery system change?

SPEAKER GINSBURG: Oh, yes. The reason we're focusing on a payment system is because we expect the delivery system will respond very vigorously to the different incentives in different payment systems.

MODERATOR ALTMAN: So now I get to the third piece. Is bigness necessarily bad, or is smallness in a delivery system necessarily good?

SPEAKER GINSBURG: No, I don't think so. I'm not convinced that we could accomplish that much simply by breaking up large delivery systems because largeness is just one of the factors behind leverage.

And often largeness can lead to upside as far as efficiency or even quality in the sense you take an ordinary community hospital and link it up with a leading hospital, and sometimes you can improve the care at the community hospital. It means that that community hospital has more leverage, but I'm not sure that the best approach would be to break that up.

MODERATOR ALTMAN: Yes, so that is very important. But you also made in your article, and I commend everyone to read the latest Health Affairs that came out before the Web one, where Paul had an article about what's going on in California.

And I think your point was that accountable care plans that integrate care but just do that, that give market power, but you have nothing on its other side, can lead to higher costs. But on the other hand, and I don't want to put words in your mouth, can we really have serious integrated care without bringing all the pieces together? And I think that's what you were --

SPEAKER GINSBURG: Yeah. Actually, my sense is I look at some of the really famous integrated systems that everyone points to providing great care, efficient care. Often a dirty little secret is they have very high payment rates.

Why? Not because they're greedy, but

because our financing system is so driven towards extensive use of services that if an integrated system uses services judiciously, they lose out. They lose big. And you know, that's why when faced with low Medicare rates, they have to have high private payer rates.

So basically with a fee-for-service payment system where many of the prices are distorted, so that we pay physicians much more for the things they do, and particularly for the facilities that they use to provide the services, that actually as long as we have a payment system like that, we can't expect much real integration of delivery.

We've known for a long time to effectively treat a congestive heart failure patient which means keeping them from coming back into the hospital by better outpatient care, large systems that have tried to do that lose money because they're not rewarded for the better outcomes, for the lower costs. They just have fewer services to bill. If that patient doesn't come back into the hospital, there's no admission to bill for.

MODERATOR ALTMAN: So as you look at Massachusetts, its structure, its strengths and its weaknesses, let me put you on the spot, what would you advise us to do?

SPEAKER GINSBURG: Actually, I've got a problem with that because in my organization, I have never made a policy recommendation. So if you could rephrase your question?

MODERATOR ALTMAN: All right. You'll leave it to me. That's fine, but -- go ahead. Rephrase your question. Well, there's a similar system out -- no, I can't. There's no way I can rephrase that question and get the answer I want.

SPEAKER GINSBURG: Yeah, I mean, you can ask me about for different options which ones I think might have a substantial impact.

MODERATOR ALTMAN: Thank you.

SPEAKER GINSBURG: But not which ones should Massachusetts do.

MODERATOR ALTMAN: Okay. So that's the question. Of the different options, Which one seems to be the preferred option?

SPEAKER GINSBURG: Well, what I would say is that as you are getting to -- reforming the payment system is the first step because I don't think any of these options, getting more engagement by consumers, a market approach or a regulatory approach when you're just regulating the prices is going to accomplish that much until you have better units of payments. And I think ultimately it's going to have to be something capitation-like or global-like.

I think that bundled episodes can play a useful role if we're selective in identifying the episodes that we want to bundle, and the ones we want to bundle are the ones that aren't discretionary, but where there's a lot of variation in costs.

So in a sense, think of hips. Hip fracture, good candidate for episode-based payments. Hip replacement, I'm not sure about that. That's much more discretionary. So I think these are the big picture payment changes. There are little -- I was impressed that all of the hospitals I interviewed in Boston were doing something to reduce hospital re-admissions.

So this is something where it just came up as a policy issue that, you know, Medicare has toyed with, you know, paying less to hospitals that have a lot of re-admissions; or I would rather them using the warranty approach of Guisinger, saying go pay them somewhat more for the first admission, and let them take care of any re-admissions. You know, you find a lot of response, a lot of hard work being done by hospitals to reduce their re-admissions.

So anyway, I think the first thing is to get a better payment system. Then I would suggest doing two things, both, you know, working on benefit structures that engage consumers to take cost into account when they choose providers, and I'd also -- if you think that Massachusetts could do it as carefully and as in a sophisticated manner that Maryland has been doing its hospital rate setting, it ought to be considered.

I don't know that Massachusetts did it that way when it did it in the 1980's. Although, I never looked at it very closely. I know that some states did it pretty carelessly; and the hospitals hated it, and then they got it repealed. So I think those are directions to look at.

MODERATOR ALTMAN: Let me, before I finish, I would appreciate if the audience would take me off the hook at some point. So if you have questions, please write them down on the cards so I can stop, you know, making a fool of myself.

So with that said, let me try one more time to push you in a little direction which I think you had just begun to talk about. I would say for myself, I'm very proud of being part of this Commonwealth and the quality of the care that we provide and the kind of providers and payers we have.

And you pointed out in your testimony that we have a rich data source that probably no other state or very few other states have; and as a matter of fact, in many respects, even better than the national. The question is, Can a state, can any state, but particularly this state, go out on its own and sort of break with the pack, break with what is going on around the country and do something significant?

SPEAKER GINSBURG: Yes. I believe that a

state like Massachusetts can go out on its own, and it may find itself influencing the rest of the country. You know, we've had examples of individual delivery systems going out on their own. It's not easy, but they seem to have maintained it.

You know, today the current popular delivery system is the Geisinger system in Pennsylvania. And you know, they have some advantages, but they really seem to be developing the type of care that the policy wants like Stuart and I talk about should be the direction, and they're doing it. And they're just one delivery system. So in a sense, I think as Massachusetts, you can do more.

I mean, sure Massachusetts cannot influence the state of the research on the effectiveness of different medical approaches, but I think there's a lot of evidence that's out there now that can be used a lot better than it has been in providing care efficiently.

MODERATOR ALTMAN: Thank you very much, Paul. Let me turn to some of the questions that I'm receiving from the audience. And then if we have time, I'll get back.

First of all, if all payers pay providers the same rates, tiered or otherwise, why not have a single payer which can get more benefits from its scale?

SPEAKER GINSBURG: Okay. I think that the difference is -- well, basically, if you -- you know, the single payer has advantages in being able to pay less for care. Basically, an all-payer rate setting accomplishes that with a multi-payer environment. This actually is what happens in Germany where they have multiple payers, but they all negotiate together with the providers.

I think that the payers can contribute a lot in their review of claims in the wellness programs that their customers asked them to develop and to have -- and just because they are free of political interference.

So I think it's a very different -- I think actually an all-payer system in some ways is a bit of a threat to the world's single-payer advocates because it's taking one of the things that single payers believe to have the potential to accomplish and doing that within our multi-payer system.

MODERATOR ALTMAN: Very good. One of the important questions, you made reference to the undesirability of price transparency. Do you see asystemetric (phonetics) information as playing a role in the rising costs of health care; and if so, how can it be addressed besides price transparency?

SPEAKER GINSBURG: Well, I think the asymmetric information between patients and providers? Is that what you think they meant?

MODERATOR ALTMAN: Pick as you feel.

SPEAKER GINSBURG: Okay, sure. I don't think it's a situation of asymmetric information because we're talking about information that patients or consumers would, even if they had it, wouldn't have anything to do with it.

In a sense, if -- you know, if their plan is going to pay the same or it's going to cost them the same no matter what provider they go to, I don't see that that information or their lack information is hurting them at all today.

MODERATOR ALTMAN: This is an important

question. It seems integration is everyone's goal. But when do you expect the savings to accrue from integrated systems? The existing integrating systems in Massachusetts have been operating for years. Why haven't they demonstrated savings?

SPEAKER GINSBURG: That's a good question, very good question. I mean, I don't know that we have the information to conclude that the integrated systems have not achieved savings.

MODERATOR ALTMAN: Now, this is an unfair question to ask, but it's probably aimed more at the politicians in the room. Could you speak to the risks that in an election year that rate caps can do to the state's health plans, hospitals and consumerism?

SPEAKER GINSBURG: No, I won't do that.

MODERATOR ALTMAN: Good answer. You know, one of the issues that doesn't come up, and I'll give you an opportunity, how can we -- and let me broaden it.

In some kind of a rate setting system or some kind of global payments, how can we deal with so-called societal goals like GME, special services, trauma, et cetera and research to be paid more in some form of a global payment system? Is that possible?

SPEAKER GINSBURG: Yeah. I think that that really is an issue. I mean, the ideal thing would be for those societal goals is that you find other ways to support them. So in a sense, an example would be that Medicare has payments for gradu-medical (phonetics) education.

You might decide that however we want society to support the extra costs of gradu-medical education, it should be done by government because it's a social objective. Because you're right, in a rate setting system, you could allow the academic medical centers to have higher rates; but then if you brought in a market system, then you're going to have consumers shunning them because of the fact that they have to pay the higher rates.

So you know, it's not an urgent problem. But the ultimate solution, and since we as a country don't like to pay more taxes, is to have the social activities funded by taxes. But since we don't want to do that, we get left to, you know, very second-best solutions of how can we protect this function that we think we agree should go forward but is not consistent with the market?

MODERATOR ALTMAN: No, I want to emphasize when I was on the Medicare Commission, we got into a to-do about GME funding independently. The then-senator from Texas went on and on. And I said, Well, the day you pass legitimate funding for GME first, then we can take it out of the Medicare payment system. But I'm waiting for you to pass it first.

So that's a very important -- ideally, most people, and at least most economists, would like to see it funded independent of the payment system; what you said. But the reality is it often gets short-threaded. And so it's been built into our payment structure.

SPEAKER GINSBURG: Because the payment structure doesn't really play much of a role these days as far as effecting where people get their care, we've been able to continue doing this second-best way without many consequences. The point is that if we actually did engage the market anymore, we wouldn't have that luxury that we have today.

MODERATOR ALTMAN: This is a very unfair question.

SPEAKER GINSBURG: I don't have a problem with that.

MODERATOR ALTMAN: Particularly for people like us. To quote a statement that you made in a previous article several years ago which I think is a terribly -- I think it's a terrible question anyway.

So with that said, you wrote a paper in 2008 about the advantages and disadvantage of costing out nursing care and incorporating nursing intensity waste. How would you bring that into any kind of a current payment system?

SPEAKER GINSBURG: Okay. If I remember that paper, that was really a very short one, it was pretty skeptical about doing that. I don't think I can remember exactly what I --

MODERATOR ALTMAN: That's what I said, it was an unfair question.

SPEAKER GINSBURG: That's right.

MODERATOR ALTMAN: But it's a good

question.

SPEAKER GINSBURG: Right.

MODERATOR ALTMAN: Particularly, it's one of my students, so I have to be very mindful. All right. Let me get one more question in.

SPEAKER GINSBURG: I didn't realize anyone would be reading that when I wrote it.

MODERATOR ALTMAN: The idea that you'd remember it, that's the hard part. This was again, you were not here, Massachusetts had what we call Chapter 495 which deregulated the hospital payment system and created a commission to monitor the impact of deregulation, two years later, the commission was dissolved because the commission said the system was working well without regulation. Please comment.

Really, what they're saying is, What happened after that?

SPEAKER GINSBURG: Actually, I don't remember the exact dates. But one thing I would say is that during the 1990's in this country, when managed care was really at its peak of power and influence, we didn't need to worry about, you know, hospital, regulating hospital payment rates because the managed care companies had narrow networks.

You know, they had no problem excluding a prominent hospital from their networks, and they had a lot of clout. I think one of the reasons that some states abandoned their rate setting system is they said, hey, we've got managed care. And I agree with them.

You don't need to do that, because managed care. There are a number of issues that are very important under fee-for-service, like self referral restrictions of physicians. It's a very critical thing. Under managed care, we didn't need that.

So in a sense, there were a lot of policy areas. It's almost like we took a ten-year vacation from it because we believed with good reason that the type of managed care we had in the 1990's was really a better way of addressing the issues.

And then what happened is we as a society decided we really don't like this. And you know, so starting in the late 1990's, managed care plans broadened their networks. They got rid of a lot of restrictions. Use went up. Capacity got tighter. And that's led to our current situation.

So you know, the 1990's, provider price was not an issue at all in private insurance. In 2010, it's a big issue. And a lot of that's because we had developed a system to address it, and then we changed our minds. And it took us quite awhile to realize we have to get back to some of the stuff we were talking about before managed care.

MODERATOR ALTMAN: Before I bring this to a close, I want to turn to David and ask, Do you have any questions of our speaker?

MS. JOHNSON: From the one brief follow-up. In your presentation, you mentioned you've noted based on the evidence that we put into the hearing that price is a factor. Utilization is also a component. But you indicated that price is maybe more of a factor recently; but in the long term, you would expect that that wouldn't be as much of a factor as utilization. I wanted to ask without intervention on the price in the market issues, do you think price is still going to be a factor?

SPEAKER GINSBURG: Yeah. I think my main point was that the, you know, the role of price has varied depending on the role of managed care, capacity. And the degree to which utilization is a smaller or a larger factor during different eras, I'm not talking percentage, but more just the absolute value, something I have been able to understand.

I've heard a number of comments lately that the growth of imaging has stopped. I don't know why. So in a sense, there's a lot of variation of every few years in the utilization trend where we don't really understand. So it's not as if we're in a position to say, oh, it's slowed down, it will remain low. I'm just saying it surprised us by slowing down. It will probably surprise us when it speeds up again.

And that, you know, long term is probably responsible for more in the growth of health spending beyond general inflation than the price factor has; but you know, the price factors are an issue at the moment. And the key thing is that we shouldn't lose track of the utilization or the volume side because we know that will be with us long-term.

MODERATOR ALTMAN: First, let me thank the audience.

COMMISSIONER MORALES: I still have one more.

MODERATOR ALTMAN: David, I'm sorry. I wasn't looking.

COMMISSIONER MORALES: No problem. Paul, thank you so much for today. As you know, there has been a lot of debate recently in the last six months and recently in the last few weeks in particular about how do we address the rapid and escalating cost in health care here specifically in Massachusetts.

I want to ask you not for your recommendation, but what do you think is in the short-term the most blunt object to use outside of rate and price setting?

SPEAKER GINSBURG: Well, the -- certainly, I would expect there will be some decentralized private market responses to that. People will trim down their benefit structure and basically get less health insurance. I think some employers may shift it to employees.

At least in Massachusetts, you don't have to worry about dropping coverage. And the -- so in a sense, but what, as blunt as it is, where could you get the fastest implants in Massachusetts? I really don't know.

And I think, you know, you're dealing with, you know, the insurance industry, not a high-margin industry, certainly in Massachusetts. Hospital industry, not a high-margin industry. So in a sense, the ability to get quick cuts that aren't just coming out of someone else's pocket is probably pretty limited.

MODERATOR ALTMAN: Any other questions? Okay. Let me again thank the audience for great questions and particularly thank our speaker. Thank you again, Paul. That was fantastic.

COMMISSIONER MORALES: Thank you, Professor Altman. We're going to take a short two-minute break to get our next panel organized.

(Short recess taken.)

COMMISSIONER MORALES: Thank you again everyone for your patience and for attending today's second part of our cost run hearings.

It's really an honor now to introduce our next moderator who will introduce our next panel. And remember prior to doing that, we will ask everyone to present under oath. But without further ado, Nancy Turnbull.

MODERATOR TURNBULL: Good afternoon, everyone.

FROM THE FLOOR: Good afternoon.

MODERATOR TURNBULL: Thank you very much. You know they say at Harvard, asleep when the class starts, your fault; asleep when the class is ended, my fault. I'm really happy to have been invited back today to moderate this panel on cost drivers.

A number of you have noticed that since Tuesday's panel, my hair is shorter. I thought if we were going to talk about some people in health care getting a haircut, I should go first. As an example, I thought I was going to be under oath, so I was going to tell you that this is my natural color; but I won't get into that. The purpose of this -- oh, you do want me under oath? It's still my natural color.

(Speakers sworn.)

MODERATOR TURNBULL: So if Tuesday was the anatomy of the health care cost problem, today I think the focus is more on the physiology of the cost problem. And some people have told me, I think falsely, that this particular panel is the truth and reconciliation panel of the cost hearing. But it's really not.

I'm hoping that we're going to have a very interesting and lively conversation. We certainly have a great panel. So I'm eager to get started. There's a lot to talk about, so I'm going to keep the introduction short. And you have full bios of everyone in your packets.

Dianne Anderson is the president and CEO of Lawrence General Hospital. I actually was planning to stop at that point, but after Tuesday's release of the AGO report and the beauty of transparency, I can tell you that Dianne's hospital is number 49 of 66 on Blue Cross's payment.

Tom Glynn is the CEO of Partners Healthcare. Tom's hospital is ranked up on this side, and is sort of in the middle here.

Dale Lodge, the President and CEO of

Winchester Healthcare Management. Dale is also in the middle of the chart. We have a good range in terms of payment disparities I think to talk about today.

Julie Pinkham is the Executive Director of the Mass. Nurses Association. Mark Gaunya is the President of Mass. Association of Health Underwriters which represents a range of people involved in employee benefits.

Andrew Dreyfus is the Executive Vice President of Blue Cross and Blue Shield of Massachusetts, the largest health insurer in the state. It's my joke with Andrew, he perhaps drew the short straw and is representing health plans today. He is outnumbered 4 to 1 I guess among providers.

Finally, my dear colleague, Nancy Kane, who is a Professor of Management and Associate Dean with the Harvard School of Public Health. Nancy, as many of you know, she's a member of the federal Medicare Payment Advisory Commission which has been mentioned a few times today. So I'm sure she'll add perspectives on many issues, but particularly how some of the payment challenges and market systems challenges here compare to some across the country.

So a great group of people to talk about this. We're going to use the same format we've used so far. Each of the panelists is going to give three to five minutes. Someone is going to try to keep them within three to five minutes. It's not going to be me actually, but thank you. Then we'll go on to questions both from me and from you as well.

So Dianne, do you want to start, and we can go I guess just down the line would be fine, so.

SPEAKER ANDERSON: Thank you. Good afternoon. I'm Dianne Anderson, the President and CEO of Lawrence General Hospital. I really welcome this opportunity and proud to tell our important story. And I really want to thank Commissioner Morales, Attorney General Coakley and her team for putting this panel together.

I'd like to say that Lawrence General Hospital is the best kept secret in the Merrimack Valley. We're a comprehensive community hospital, about 200 beds, and we have the third busiest emergency department in the state. One that sees about 78,000 visits a year.

We have some unique features such as an accredited trauma program and a nationally-known family practice residency. We are a natural medical home for a large population in the poorest community of the state and really an example of high access, high quality and low cost care.

However, it is not sustainable long-term with our current private and government payer rates. Lawrence General is a disproportionate share hospital that serves a largely Latino population. We have the highest proportion of Medicare patients of any community hospital in the state, and our private payers make up only 24 percent of our revenue. So we don't have the same market clout to negotiate the same rates as all hospitals.

We are a case study for the Attorney General's findings that insurers pay substantially lower rates for hospitals like Lawrence General and that the reimbursement system is truly broken.

In fact, the rate data provided for these hearings by the state's three largest health plans made it crystal clear. Lawrence General and other disproportionate share hospitals like us are the worst paid hospitals in the state.

From '04 to '06, Harvard Pilgrim paid Lawrence General the lowest rate in the state, 69 out of 69. For the most recent years, Tufts paid us only 69 percent of the hospital average and Blue Cross about 89 percent of the average medical costs. Our physicians do not fair much better. For Harvard Pilgrim, they're paid in the bottom 15 percent; and for Tufts, 19 percent below average.

At the same time, Medicaid which accounts for 34 percent of our gross revenue pays us less than 70 percent of our cost and in the past two years has cut our Medicaid outpatient rates by 10 percent, cut all support for our training program of our 24 residents in the family practice residency program. This is a program that was created to ensure primary care access for Medicaid patients.

And even our Medicaid inpatient rates are only 2.6 percent higher today than they were five years ago. We've taken many steps through the years to control costs and stay profitable, reduce FTE's, refine contracts, vendor contracts, opened up new services and automated.

We believe we're very nimble, but we have no more low-hanging fruit in terms of programs and services to cut. While we see other hospitals and doctors in our area getting higher rates, our low rates do not allow us to invest in our physical plant, new capital or information technology. As a result, our hospital buildings are more than 50 years old and desperately need replacement. And our information technology requires significant investment.

We pay a premium to borrow because the markets look unfavorably on our reliance on government payers. It is very difficult for us to compete with other hospitals that get better rates for privately-insured patients. And our ability to continue the comprehensive care our community and patients deserve in the long-term is threatened.

We're also the largest employer in Lawrence in an area with an unemployment rate of 16 percent. We face the same pressures as everyone else on wages and benefits, medical malpractice and capital equipment. Our patients require additional services such as interpreters, financial counseling and dedicated bilingual primary care providers.

Together, with Greater Lawrence Health Center, we created a national model for training family practice residents. We trained 102 physicians in the past few years and added more than 20 physicians currently to Lawrence. This program is in jeopardy in the future without reimbursement.

In the recent months, the State, experimenting with the new health plan, CeltiCare, and its selected provider network tried to redirect legal immigrants who relied on us as a medical home to a hospital outside of Lawrence. We needed our legislative delegation and the press to help tell our story to continue to provide care to our patients.

This flies in the face of health care

reform as I understand it, which is high access, low cost and high quality. The CeltiCare experience was a red flag to us that market clout and leverage will determine network development's selective contracting in the same way it does overpricing.

Larger systems have the market power to dominate and sideline excellent providers like us. There is no reason why physicians with the same training, credentials, experience providing care at hospitals with no difference in quality or outcome should be paid vastly lower prices.

We believe that we are a model hospital to be a solution for health care reform for low cost, high quality and local; but unfortunately, our current private and government payer rates do not recognize that fact. We are grossly underpaid for our value.

We believe there is a critical need for strong, vibrant community hospitals to provide outstanding cost-effective care close to home. We provide an excellent local affordable care model, but only if the reimbursement playing ground is made level. Thank you for this opportunity.

SPEAKER DREYFUS: Good afternoon, Commissioner Morales, Assistant Attorney General Johnson, our distinguished moderator with the nice hair and fellow panelists and guests. My name is Andrew Dreyfus, Executive Vice President for Health Care Services at Blue Cross and Blue Shield of Massachusetts. Thank you for the opportunity to make some brief remarks to frame our written response to questions posed by the Division and by the Office of the Attorney General.

Blue Cross is acutely aware that the health care costs in this state are rising at a rate that is not sustainable for individuals, families, business or government. In the current economic climate, this is especially true for small business.

What's more, despite the high standards of health care in Massachusetts, no one believes that we're getting the best value for our health care dollars in terms of maximizing the quality and the safety of patient care.

As a local not-for-profit health plan, employer, established member of the business community, and an enthusiastic participant in Massachusetts Health Care Reform, Blue Cross is deeply committed to and engaged in developing constructive solutions to our affordability crisis.

Recent studies and reports produced by and for the Commonwealth have confirmed that rising health insurance premiums are being driven almost entirely by the growth in underlying medical costs. That is certainly the case at Blue Cross where approximately 90 cents, 90 percent of the premium pays for medical services we purchase on behalf of our members and the remaining 10 percent pays for administration.

The written response we submitted for this hearing explains in detail how Blue Cross accounts for and allocates our costs. In general, the unit costs account for approximately 50 percent of our annual increases in our medical spending. This is a result of paying hospitals, physicians and other care providers more per unit of service.

Increased utilization of services such as specialty pharmacy or lab and radiology services constitute as much as 25 percent of medical cost trends. And the mix of providers our members use account for about 20 percent including shifts in care from lower to higher cost settings. All three of these factors, cost, utilization and provider mix must be considered in any effort to bend the trend along with continuous health and quality improvement.

Let me first address the other part of the equation, our administrative costs. The 10 cents of every premium dollar we spend on administration includes salary and benefits, other typical business expenses, technology investments and a wide range of care management programs aimed at improving the health of our members.

To lower our administrative costs and maximize the value of each dollar spent, we have taken significant steps to run our business more efficiently and effectively. We eliminated $40 million of administrative costs in 2009 equal to about a 4 percent reduction and have identified an additional 40 million in savings in 2010 and beyond.

This effort included reducing the size of our workforce as many other employers have done. While these substantial administrative savings are important, they're easily overwhelmed by rising medical costs. As the National Association of Insurance Commissioners stated in the February 23rd letter to Congress, "The single most significant contributor to rising health insurance premiums has clearly been the continued growth of health care spending, which must be addressed through payment reform, delivery system changes and emphasis on prevention and consumer engagement."

We are convinced that payment reform will support high-quality care and reduce per capita spending over time, and our Alternative Quality Contract which we introduced last year is one example of how it can be done.

Another opportunity that is both promising and challenging is consumer or patient engagement. Here the paradigm needs to change from one where involvement too often means benefit buy-downs and increased patient cost-sharing to one of true engagement with consumers benefiting by making informed choices about quality and cost.

To that end, we have introduced and continued to develop new products to encourage members and referring providers to choose high-quality, cost-efficient providers and services.

Thanks to the drafters of Chapter 305, health care reform 2.0, the Commonwealth has a broad process underway for understanding and tackling health care costs, including these hearings. The complexity of the problem is a mess, but let's not forget that a blueprint for addressing the affordability of health care was written and approved by the Payment Reform Commission, which voted unanimously to move away from the current fee-for-service system to a global provider system with significant quality incentives.

While a sound transition to global payments statewide will take time, it must start immediately. And state government has a central role to play in ensuring a successful transition. Each step we take in Massachusetts on the way to health care reform requires collaboration among all the stakeholders to contain the underlying medical costs driving premium increases while continuing improving quality.

Blue Cross will continue to propose and implement meaningful, sustainable solutions, and we look forward to working with you as you develop your recommendations. Thank you.

SPEAKER GAUNYA: Good afternoon, everybody. My name is Mark Gaunya, and I'm the president of the Massachusetts Association of Health Underwriters, a not-for-profit organization representing over a thousand licensed employee benefit professionals and thousands of employers and their employees all across the Commonwealth of Massachusetts.

It is my distinct honor and privilege to be invited to participate in this panel of distinguished health care experts, and I greatly appreciate Commissioner Morales' invitation. By way of background, I've spent the better part of my life in and around health care and believe my 21-year career in the provider, payer and employee benefits brokerage and consulting industries will provide this panel with a unique perspective on the rising health care cost challenge and how it effects the consumers of Massachusetts.

Initially, I planned to talk about the rising cost of health care and some of the facts and figures behind that, but I think the panelists you've heard before today and the panelists you've heard so far have already talked about that in great detail.

I will share with you that we are No. 1 in the nation with 97.4 percent of our residents insured versus the national average of 83 percent. Our health plan designs though are 27 percent richer on average, meaning they have lower deductibles and lower out-of-pocket cost sharing, and our health care costs on average are 15 percent higher.

Solving the rising health care cost challenge is akin to working with a Rubix Cube because it has many moving parts and possible combinations to get the right answer. But one thing is clear, health insurance is expensive because health care is expensive.

In 2009, three of the top four health plans posted significant operating losses ranging from 10 to $150 million. In Q1 2010, health plan rate increases for small groups, those with less than 50 employees, average between 25 and 40 percent. In a weak economy, employers and consumers are demanding answers and solutions. The question is, Are we looking in the right places and asking the right questions?

Let's start with the defining health care trend and its components. Simplistically, health care trend is the combination of provider unit costs, a utilization of health care products and services by consumers. By most estimates, health care trend in Massachusetts is roughly between 10 and 12 percent, and it's broken down 75 percent unit cost, 25 percent utilization or units of service.

Next let's provide a high level overview of the Massachusetts health care system in spending trends for privately insured residents. No. 1, there's greater availability in our market and use of more expensive academic medical centers and use of outpatient hospital-based facilities for some services that could be provided in less costly settings.

No. 2, higher number of specialty doctors rather than primary care doctors and a health care system dominated by academic medical centers, both of which tend to provide more expensive care.

No. 3, a higher concentration of doctors in academic medical centers compared to national averages.

And No. 4, increases in spending were more heavily directed toward outpatient hospital services which saw growth in unit costs and utilization of imaging services, medical procedures and cancer therapies.

With that information in mind, let's examine the Attorney General's Office report on January 29th, which analyzes health care costs, trends and cost drivers. The report clearly identifies and concludes that contracting relationships between health care providers and health plans is the primary driver of health insurance premium increases.

More specifically, the report suggests

that No. 1, reimbursement rates for health care providers are consistently inconsistent within the same geographic area and amongst providers offering similar services.

No. 2, reimbursement rates are not correlated to the quality of care delivered, the sickness or complexity of the population being served, the mix of Medicare and Medicaid patients, the classification as an academic or a research facility or the underlying cost structure.

No. 3, reimbursement rates are correlated to market leverage based on size, geography and brand.

No. 4, variation in total medical expenses is not correlated to the methodology used to pay for health care services; i.e., the difference between discounted fee-for-service and global payment. In fact, the report suggests global payment can cost more depending on how the program is structured.

No. 5, increases in reimbursement rates are the primary driver of health plan premium rate increases, not excessive health plan administrative costs.

No. 6, the commercial health plan market has been distorted by contracting practices that perpetuate market leverage and prioritize competitive position over consumer value.

But what about the consumer of health care products and services? What is their role in this challenge? I intended on Tuesday and I was distraught by the notorious absence, being briefly mentioned in most of the discussions relative to the consumer's role in health care.

In our view, consumers also play a very big role in the rising cost of health care, and their lifestyle choices and health care decisions are required to bend the health care trend.

Twisting the cube to solve the problem: In every industry, sound economic models address both supply and demand to improve quality and control costs. Supply-side solutions in health care include, but are not limited to, restricting provider network access, changes to the reimbursement methodologies between providers and health plans, availability of innovative products and services; and 4., government regulation.

Demand-side solutions include, but are not limited to, consumer engagement, education and empowerment through the fundamental principles of transparency of cost and quality, individual responsibility to make healthy lifestyle choices and informed purchasing decisions, and the opportunity to be physically and financially better off if you make those informed choices.

Other cost containment tools include tort reform to reduce the impact of medical liability and to curb the defensive practice of medicine, the evaluation of state-mandated benefits; and finally, the evaluation of minimum creditable coverage standards under the Mass. Healthcare Reform Law.

As the AG accurately pointed out, and we fully agree, working together, policymakers, health plans, providers, employers and consumers can deliver the health care quality and value that the people of Massachusetts deserve. Thank you.

SPEAKER GLYNN: Good afternoon, Commissioner Morales, Assistant Attorney General

Johnson, our moderator and other members of the panel. My name is Tom Glynn. I'm the chief operating officer for Partners Healthcare. To provide some context for my perspective, perhaps I should mention that I served in the Clinton Administration under Bob Reich as Deputy Secretary of the U.S. Department of Labor which oversees ERISA.

Earlier in my career, I served as Deputy Commissioner of the Massachusetts Department of Public Welfare, as it was then called, under Governor Dukakis during the time when Medicaid was under the Welfare Department.

Partners Healthcare System welcomes this community dialogue on the many factors contributing to rising health care costs in Massachusetts and at the national level. We look forward to working with all key stakeholders, clinicians, insurers, employers, consumers and state government leaders to develop evidenced-based sustainable long-term solutions to ensure that Massachusetts patients maintain their access to high-quality care that is also affordable.

We applaud Senate President Therese Murray for bringing the issue of health care costs to the forefront of public discussion through Chapter 305. We congratulate Governor Patrick and the Attorney General for their ongoing data-driven review and analysis of factors influencing health care costs, premiums and the structure of the current marketplace.

Such data is needed to take a deliberate and effective approach to reforming the state's health care system, an economic engine that is a critical component of our economy, employing one out of every six workers and contributing a significant 13 percent of the state's gross domestic product, gross state product.

Without the correct diagnosis of the problem, we are likely to get the wrong remedy. We therefore applaud the Patrick Administration for commissioning several analyses and engaging multiple experts to peel away the complex layers of the health care cost puzzle in an effort to develop solutions; including, 1., the RAND Corporation, August 2009 analysis, Controlling Health Care Spending in Massachusetts: An

Analysis of Options;

2., the Division of Health Care Finance and Policy reports that came out recently;

3., the hearings conducted by The Division of Insurance;

And 4., the analysis commissioned by the Health Care Quality and Cost Council in September that evaluates the impact of freezing provider payment rates and health insurance premiums.

Today, Partners Healthcare would like to endorse the rigorous and thoughtful analyses conducted by the RAND Corporation and the cost trends reports done by Brandeis' Heller School. These reports highlight important factors contributing to health care spending and premium increases in Massachusetts and provide data-driven analysis from which evidence-based solutions should be developed in considering policy options.

These analyses also highlight the challenges of recommending a one-size-fits-all policy solution when, as the report shows, there is great variability what is driving cost trends. There is also great variability in the ranges of predicted savings and sometimes limited empirical and theoretical evidence to reach definitive conclusions.

Partners Healthcare supports the rate analysis which shows the following ways to address the cost pressures. 1., bundle payments; 2., medical home; 3., health information technology.

The Brandeis health care cost trend report provides a well-balanced, comprehensive analysis of factors contributing to health care costs in Massachusetts. We acknowledge that these factors play a role in underlying cost trends.

As the analysis indicates, 1., Massachusetts has a high concentration of medical personnel, including specialists and residents. 2., Massachusetts has a large proportion of care provided by academic medical centers. 3., due to the state's commitment to ensure access care to all, we can probably say that Massachusetts has the highest insurance rate in the country with over 97 percent of the population insured.

And we agree, as the report states, that broader coverage and more generous benefits contribute to the cost growth as well. 4., the predominant payment method for paying physicians at hospitals in Massachusetts is via fee-for-service methodology which provides limited incentives for providers to increase efficiency or improve quality of care.

Partners agrees that fee-for-service payments not linked to performance are a factor contributing to increasing cost trends. That's why Partners has pay for performance contracts with major commercial payers. Dr. Gary Gottlieb will discuss further details tomorrow about the limitations of the current fee-for-service system and how we propose to change it in his testimony in the panel on solutions.

The challenges of managing health care costs is a national issue and not unique to Massachusetts. In this light and as the Brandeis report highlights, the growth trend for health care spending in Massachusetts is similar to the U.S.

In addition, after adjusting for higher income, housing, utility and other necessities, Massachusetts personal health care spending is 13 percent of gross state product, ranking not at the top, but in the middle of the 50 states. This is especially striking given that the Massachusetts labor, utility, and real estate costs are significantly higher than the national average.

As the community dialogue continues and the pressures mount to push policymakers to develop solutions, we need to ensure that the true drivers, true key drivers of cost growth are the targets of policy solutions aimed at curbing them.

The Patrick Administration, the legislature, the Attorney General and all stakeholders have a challenging task ahead of ensuring that their solutions will reduce the rate of spending in Massachusetts while preserving the economic engine that is so critical to our workforce, our patients and our future economic prosperity.

We look forward to working with the Patrick Administration, the Attorney General and the Legislature to identify key health care cost drivers in Massachusetts and to develop solutions to tackle them.

SPEAKER LODGE: Good afternoon. Thank you, Commissioner. I appreciate the opportunity to be here. Hopefully, I'm going to try to say some things that are a little bit different than everybody else has repeated. Actually, some of this may be more ad hoc since I had some experiences today that may apply.

My background, if you read my biography, I'm the President and CEO of Winchester Healthcare Management which is the parent company of both a hospital and a medical group. We are managing both physicians and a hospital and working hard to become an integrated delivery system at least at our level.

We support -- and frankly, we're, for those of you who don't know where we're located, we're about eight or nine miles outside of Boston. We have some significant competition. We send a truck into Storrow Drive everyday to try to plug up the tunnels down there to make sure no one can get in, but that doesn't always work.

We've actually decided that what we should do is focus on patient experience at Winchester Hospital. We're actually proud to be named the No. 1 employer in Boston for two years in a row, really by two significant, both the Boston Business Journal and the Boston Globe. Part of that is not just because we want happy employees; but the truth is where we think we can be different is if you come to Winchester Hospital, hopefully you're going to have a better patient experience.

If you take a look at our cost structure or public data, whatever public data you have out there, we actually think we're very, very competitive right now. And we think we're paid relatively fairly. So we're not talking about that the payment methods are very, very different.

In my history, so people are aware, I used to have some of Andrew's responsibilities back in the old days when things were very, very different. I think this is an important fact that people ought to realize. Things have changed in the last twelve to thirteen years.

When I did contracting on behalf of Blue Cross and Blue Shield, A., there were selective networks, significant selective networks. People were restricted where they could go and where they could receive services. And frankly, many of those selective networks grew to 500,000 people and excluded many high-cost providers when they existed at that time.

Commercial rates back in those days, by the way, were negotiated, for the most part were about 75 percent of costs. Medicare, on the other hand, was paying almost 130 percent of cost. That has almost completely reversed itself in the last twelve years.

So what you have is government payers who used to subsidize commercial payers, and now you've got commercial payers subsidizing commercial payers. A very big issue.

Dr. Ginsburg mentioned, which I think is an important solution going forward, is that those societal costs, whatever they may be, teaching, research, Medicare shortfalls, Medicaid shortfalls, Free Care Pool supports maybe ought to be through a tax, a direct tax rather than hiding that tax in a premium that gets inflated out there. It could go a long ways to trying to solve this problem of what things are. Then people would really know what they're getting when they buy health insurance.

The other thing, I've heard all kinds of conversations about what needs to be done to providers and provider payments, whether it's capitation or whatever else you come out with. I had a very interesting conversation this morning along the Mass. Business Roundtables Health Care Advisory Group, and there happened to be a major plan there and a major employer there.

And they were discussing one of the employees from that employer. And that employee had found out that because of some contracting thing, they had to receive or should be receiving their services in a particular group of caregivers. And it was kind of news to them because their product really doesn't sell itself as that. It sells itself as a full access network.

So the employer representative said, you know, this is very difficult for us to deal with.

And the insurance company said, well, you know, the provider group really should manage that in making sure that the patient is educated. What I recommended is not the provider group's responsibility alone.

It is the employer group's responsibility to educate. It is the health plan that sells it to educate and make sure that everybody is party to, in fact, what this arrangement ought to be in the end.

I do think -- I used to be the Chair of the Mass. Hospital Association. It actually had put out a very good paper recently. I will endorse it. It does say as we're going down the payment reform path, there are benefit changes that need to be implemented, and they need to be part of the old package.

So if you're going to do capitation, have a product that aligns with the provider contracting strategy so that everybody, whether you're the beneficiary, you're the provider or you're the insurance, you're all aligned; and nobody's confused about what they ought to be doing. The rules of the game are clear.

I will say one last thing, and this comes from my experience with my daughter who was a student of Regina Herzlinger. And she discussed a program in Switzerland. And one of the things that we don't talk enough about is how we encourage and truly encourage people to have a healthy lifestyle.

So in Switzerland, the program that worked there, I may not have this perfectly right, but I'll be short. I have one minute. Essentially you buy insurance. You as an individual buy insurance in the marketplace. You buy it for five-year periods of time.

And you will get a rebate on your premium for different lifestyle events, A., if you don't smoke; this one I don't particularly like, you don't drink; and you maintain your weight; you exercise. So good lifestyles, you could get up to as much as a 50 percent return on your premium for adhering to it.

How it works, all the details of it, but it really says in the end it can't just be a provider reimbursement strategy. It's not a health plan issue all on its own. It is a partnership much like the partnership that got put together with getting 97 percent of this population insured.

And no matter what we talk about today, everybody ought to be pretty proud of that. I mean, this is the state in the union that does that. If we've accomplished nothing, we have 97 percent of this population insured, and that's a great victory. That's it. Thank you.

SPEAKER PINKHAM: Good afternoon. I guess no time for pleasantries because I have five minutes, so. My name is Julie Pinkham. I'm the Executive Director of the Massachusetts Nurses Association. We represent 23,000 registered nurses and health professionals in Massachusetts.

We have 70 percent of the registered nurses or 70 percent of the acute care hospitals in Massachusetts, we represent the registered nurses. We've taken the opportunity to analyze the wage data.

I thank you very much to the Division for providing all the data. Also, I wanted to thank Judy Rothchild for assisting all of my staff who have been working diligently to take a look at the wage data and answer two specific questions.

The first is, Are nursing wages a cost driver in the escalation of health care costs in Massachusetts? The second question we looked at is, Is the data of the Attorney General and the Division reflective of the reality experienced by the registered nurses?

So focusing on the first, at the beginning of the decade, RN wages in Massachusetts and Boston and national were similar. However, unlike RN labor workforce participation nationally, RN labor workforce participation in Massachusetts fell and continued to decline.

In the MNA's view, it was a combination of the failed RN work redesign strategies that led to a three-year decline in Massachusetts. RN labor force participation began to improve when hospitals abandoned work redesign models that substituted unlicensed personnel for registered nurses.

The demand caused by the failed redesign strategies and the subsequent nursing shortage led to substantial RN wage increases both to recruit and to retain RN's. When RN wages declined to unacceptable levels and/or working conditions deteriorated, the RN labor workforce participation declined. Hospital vacancy rates subsequently rose, triggering a familiar cycle of RN shortages and understaffing in Massachusetts hospitals.

We found in our analysis that the RN wage cost as a percent of the total hospital budget has been between 17 and 18 percent for the past five years. I've attached some charts to the testimony in which we've actually taken the various hospitals and divied them up in a variety of different ways, whether by size, teaching, geography, every different disproportionate share, we looked at it pretty much every different way that we could.

And the range went from 12.5 to 17.5 percent of the total expense. And that again, as I say, it's been flat. We also took a look at RN wage increases from 2005 to 2010 and found that they were on pace with inflation and most recently have now begun to decline.

In '05, it was roughly 4 percent. It has now declined to 2.5 percent. It's important to recognize that there's a marked variation in RN wages across Massachusetts. The MNA's analysis and the data from the U.S. Bureau of Labor Statistics concur that higher RN wages in Massachusetts cluster around Boston teaching hospitals.

MNA RN wage markets are primarily defined by geography and teaching status. Boston hospitals must compete for RN labor workforces to work in a tertiary care teaching setting regardless of the relative profitability of the hospital. This is similarly true throughout geographic areas of the state.

Contract negotiations for wage rate are patterned by geography and teaching status more so than profitability and/or network affiliation status. The union and non-union wages are not significantly different. Non-union facilities will pattern their wages to remain market competitive with union wages as contracts are negotiated.

For non-union facilities this is both a

recruit and retention effort and a no-doubt method to deter nurses from unionizing. The MNA's analysis of RN wages, hospital demographic and financial data from the Division found that RN wages were significantly associated with teaching status.

Hospital profit was also a relevant factor, though the impact as a percentage of hospital expense remains stable or flat. MNA's analysis did not find an association between RN wages and total hospital charges or hospital charges for separate medical and surgical procedures.

Succinctly, the analysis of the Department of Labor, the Division of Health Care Quality and Finance, MNA wage data reveals the RN wages are not connected to the concerning increases of the Massachusetts health care costs.

I'm going to skip because I'm going to lose here. We then focus on the second question, and that is, Is the relative experience of the data found by the AG that of the experience of registered nurses in Massachusetts, specifically quoting the prices paid to the hospitals do not correlate to the acuity or complexity of the cases handled by the hospital as measured by hospital case mix index.

The nursing profession has long recognized that using diagnostic-related groups or DRG's or CMI case mix index as a proxy for the complexity of acuity of patient care is a problem. Specifically, DRG's and CMI's failed to account for the intensity of nursing care needs for the patients.

I'm now skipping. I have attached an article by Welton to my testimony. We found that in this article, adding nursing intensity adjustment to the existing inpatient billing improved in explaining the variance of Massachusetts hospital cost values, 12.7 percent for all payers.

The MNA believes the conclusion of the preliminary report that the variance of hospital costs can't be explained by the severity of complexity of care as flawed by the indices used in the analysis which failed to account for the intensity of nursing care.

While this will not account for all of

the variances, it is significant. Addressing this component along with other components effecting price variance provides a cumulative approach that is, in our opinion, the way to address the issues rather than seeking a syllabic resolution.

Lastly, we would say -- I'm speaking over this. Lastly, we would say that it's ironic that we're speaking today in terms of RN wages and the cost of RN's when the only reason why you actually stay in a Massachusetts hospital from our standpoint is because you need 24-hour clinical RN supervision. Otherwise, your care would be delivered outside of the hospital.

But yet, in part, and when we look at the budget, nowhere can you find RN costs. They are lumped in under, you know, general costs. It's not teased out. We would hardly recommend that not only the issue of nursing intensity be looked at, but also that the licensed RN costs are indeed peeled out from the budget so that they can be analyzed. Thank you.

SPEAKER KANE: Thank you. I've been asked to comment on the, to diagnose the reasons for rising health care costs. I guess because I've had some national experience with the Medicare Payment Commission, Advisory Commission, which by the way, I cannot represent their opinions. I can only represent my own.

But I can start to perhaps draw some parallels between what's going on in Massachusetts and what's going on nationally. I can only say that comparing Massachusetts to what's going on in the nation doesn't necessarily make us better or worse because what's going on in the nation is actually quite problematic as well.

So basically the long-run costs of escalating health care, long-range causes have been pretty well identified I think in the last few speakers as well as the prior speakers; and they include national wealth, advancing in technology, getting older, inflation, and even being insured does encourage escalating health care costs.

Since the early 1960's, since we basically had Medicare and Medicaid, health care costs have grown 2 percent or more faster than

GDP. And it's been fairly studied for the last 40 or 50 years. While policymakers obviously don't want to reduce wealth or advances in technology, there remain still some very important and potentially influential leaders that we could use to help keep health care costs growth affordable.

These include policies that relate price levels to value that modify payment units to encourage providers to provide provider value-based care including the appropriate use of technology. And finally, policies that encourage value-based benefit design that promotes appropriate consumer decision-making.

When I use the word *value* in this context, I mean affordable, accessible and efficiently delivered care that delivers the best possible health care outcomes to the citizens of Massachusetts.

In other words, I don't necessarily think health care policy should guarantee employment or maintain an industry that isn't affordable in providing the kind of care that we think our citizens deserve.

In terms of pricing levels, I think the Attorney General's study recently released does show the differentials across hospitals and physicians are a function of provider market and political power and not value as I defined it earlier.

Similarly, political leverage effects prices that even Medicare pays. For instance, academic medical centers receive add-ons to their DRG rates for indirect graduate medical education that's twice as high as the empirically justified costs which sends $3 billion in additional revenue to academic medical centers nationwide every year in excess of their empirical costs.

This enables them, in fact, to compete better against community hospitals that don't get these kinds of payments. Similar disparities based on political leverage and payment design flaws are evident in the Medicare relative value scale which have gotten worse over time and have resulted in payment rates that pay some specialists more than 200 percent more per hour than primary care physicians without any other explanatory variables.

This has contributed to a distorted supply of physicians nationwide. In Massachusetts, for instance, only about 35 percent of physicians report that adult primary care is their only specialty; and the disparities in access to primary care seem to be worsening.

Payment equity within systems as well as between payers and providers may also be required in order to push delivery system toward greater, higher value care. For instance, one of my physicians -- I trained physicians to become managers in this health care system, and they're constantly writing me little anecdotes to support things they've learned in our program.

One of them wrote, "My health system has just decreased the dollars per RVU so that my salary will not go up when more RVU's are attached to follow-up care and management." This is a doctor who does a lot of cognitive, non-procedural type care.

"Meanwhile, the procedurals are staying higher. For instance, my RVU's went from $50 to 44, while the orthopedists and pain management specialists stayed in the $60 range. Recently, I saw a lady who had gone from an orthopedist to a neurosurgeon specializing in spines who did a lumbar and cervical spinal fusion."

"The patient continued to get weak. She saw me, and I diagnosed that she had ALS. She didn't need the fusions after all. My visit cost $150. Her fusions cost over $50,000. The comparison is priceless."

Both the Attorney General's report and the Special Commission on Payment Reform recommend reducing pricing disparities that are not based on value. While I agree with the Attorney General that global rates alone will not address disparities and the growth of commercial rates, it would be extremely shortsighted to focus only on the level of pricing and not on the incentives that the pricing unit presents to providers.

While utilization may account for only 25 percent of the increase in commercial rates in Massachusetts in recent years, it accounts for a much greater percentage of the increase in per capita spending in the Medicare program which administers prices, does not negotiate them. So obviously, utilization will be a much bigger problem for them.

While price increases accounted for about 20 percent of the increase in per capita Medicare spending over the last ten years, volume per beneficiary increased by another 70 percent. For physicians services, volume has grown even faster on a per capita basis.

While there are many reasons for the rapid growth in outpatient utilization, it's pretty clear that that the utilization of outpatient is contributing quite a bit more than just the pricing increases alone.

Much of the long-term increase in health care costs is attributed to new technology, some of which add great value, and others of which are of dubious values. Many researchers have suggested that new technologies adopted in the last decade may not have the same value that they had in prior decades.

Unfortunately, it is not often obvious which technologies fall into which category. Both the state and the federal government need to foster comparative effectiveness, research and dissemination.

Finally, the incentive to use new technologies which often, new technology which often carries higher price tags than the technologies they replace is much greater under the fee-for-service incentives than under more value-based and bundled than the much bundled payment systems.

I'm going to move on now to talking a little bit about payment on fee-for-service. Just to conclude, it's inherently inflationary and doesn't respect the value-based payment principles. Finally, in terms of value-based benefit design, both Medicare and most private sector insurance coverage offer weak to nonexistent incentives for patients to make appropriate and value-based choices in health care.

Deductibles and copays are often indiscriminate and discourage both high value and low value care. Recent analysis of Medicare cost sharing, for instance, highlights the differences in utilization between beneficiaries with and without Medigap policies.

Medicare beneficiaries with Medigap policies spent between 17 and 33 percent more, depending on the policy, than those without Medigap policies. We can't tell whether the spending, additional spending was appropriate or not or whether the non-Medigap spending was appropriate.

So I look forward to discussing these issues and also with Andrew Dreyfus agree that the Special Commission on Payment Reform which met for six months on hard plastic seats without lunch did issue a report that I think gives the state a blueprint for how to modify the payment system to encourage much better value for our health care dollar. Thank you.

MODERATOR TURNBULL: Thanks to all of you. So I'm going to, I have some questions that I want to ask. Any of you want to ask questions, there are people circulating with white note cards. So please join in.

So I'm going to start with the Division and the AG's report that showed prices rather than utilization are the primary driver leading to increasing health care costs. A number of you, including Andrew and others seem to concur with that.

Tom, I want to start with you. In your comments, you just said that we should focus on the true key drivers of health care cost growth. So I wanted to know, What do you think those are?

SPEAKER GLYNN: I think that Nancy did a good job laying out some of them. I mean, one of them is technology. Another one of them is the aging of the population. Another one is the increasing utilization.

I think that price has a role in that. I just don't think it placed quite the role that some people have suggested. And I think that the national studies that have been done looking at this over time, you know, the CBO did an analysis about two years ago kind of looking at the three major national studies; one of them done by David Cutler who some people know locally, suggested that technology was probably responsible for roughly half, and the other factors were responsible for the other half.

So you know, I just think it requires a little bit of an understanding these different pieces of the puzzle

MODERATOR TURNBULL: Andrew, in your testimony, you said price accounted for I think it was 50 percent of your pricing?

SPEAKER DREYFUS: Yes.

MODERATOR TURNBULL: Do you agree with Tom or not?

SPEAKER DREYFUS: We made a distinction, and the Attorney General's report captured this that none of the other plans did which is we had three components of trend. One was what we call pure pricing. Another one was utilization we've talked about, and the third was the mix.

Then the Attorney General may have just been a kind of taxonomy question. They included mix as part of price which is a reasonable conclusion. We think it's important to segregate because as you start to think of what are the interventions, you need to understand at that level.

But I'd like to have a few thoughts about price and about disparities. One thing is about, as I think both Paul Ginsburg and Stuart suggested and Nancy, that if we constrain price, we will see utilization come back. And there's strong evidence of that over time.

And so unless we have a system which tries to ask physicians and hospitals to take accountability for both price and utilization, which global payments do, then I don't think we're going to get at the root of the problem.

The other thing that I thought was very helpful in the Attorney General's report but not discussed, at least in the part of the hearings that I've seen, are a focus on total medical expense which combines to some extent price and utilization.

First of all, you see a smaller disparity on total medical expense than you do simply on price. So for example, it's also what most contributes to premium. We increasingly are using tiering and tiered networks, which are part of the value-based design that I think several people recommended.

We tier primary care physicians. We don't tier them based on price. We tier them based on total medical expense. I think that's an important point. I guess, finally, I'd say that when we look at price, let's not always assume that the lowest price is bad.

I understand we heard from Lawrence General Hospital about the serious financial challenges they face by being a low-paid hospital both from public and private payers. But we need low-cost providers in our states in order to design the kind of value-based products that I think everyone are calling for.

In some ways, I think Dale presented what he considered his hospital as a kind of moderate cost alternative. And I worry if we just focus on price what we'll end up focusing on and we'll see is a kind of race to the top where all the lower paid physicians and hospitals will essentially seek higher payments, and we'll have a race to the top.

Finally, I was interested in what Nancy said about Medicare because we did a quick analysis to look at what are the disparities in payment rates to hospitals in Massachusetts from Medicare which is a regulated, fixed-priced system. And we found they're pretty substantial; not quite as substantial as they are in the private commercial market, but substantial nonetheless.

So whether we had a regulated system or we have a competitive system, we still have a disparity which is why we need to look at the total cost of care which we think is what global payments begins to do.

MODERATOR TURNBULL: You packed a lot into that, some of which we'll come back to again. Dianne or Dale, you were leading in, so.

SPEAKER ANDERSON: Yes, I would like to make a comment. I actually agree with you, Andrew. I think we do need low-cost providers in the state but not underpaid for value. I think that's an issue that's been clearly brought forth by the AG's report and certainly by the various panelists we've heard so far.

We believe, for example, that we can really help be a solution to that by, you know, I'm intrigued by the notions of some of the leveling pricing according to value and some of the things that have been discussed today because if we could at least true up some of the pricing in the system so that we can provide the same level of care and infrastructure and information technology, we can continue to be even higher value and be even more efficient than we are right now.

MODERATOR TURNBULL: That's helpful. Dale, did you want to talk?

SPEAKER GLYNN: I don't know if I'm allowed to have another?

MODERATOR TURNBULL: You can have another until I tell you you can't.

SPEAKER GLYNN: I do want to pick up on something that Dale said which I think it relevant to this part of the conversation about what is driving up costs. He made the observation about what's happened with Medicare reimbursement over the years. And just to kind of reiterate, in the early 1990's, it was about 130 percent of cost.

Now it's down to around, depending on who you talk to, it's certainly less than 90. I think in the report, that one of the DHCFP reports it says that the national average for private payers is 132 percent of cost in order to subsidize Medicare losses and Medicaid losses.

So one of the factors in driving up the

cost of the premium is the fact that we're getting about 70 cents on the dollar for Medicaid and about 90 cents on the dollar from Medicare. Roughly, 18 percent of the money that we charge Andrew is to make up for the losses in Medicare and Medicaid.

And so as those get worse, there's more pressure on the private side of the equation. I think Dale put this idea in play in an important way, and I think that needs to be factored into the equation particularly given, you know, the fact that there's more pressure at the federal level now on the Medicare budget and, you know, the Medicaid budget doesn't seem to be improving in terms of cents on the dollar for hospitals.

MODERATOR TURNBULL: Well, let's pick up on the cost shifting. I was going to come to that later, but -- I think in the last day and a half, we've heard actually two different stories about cost shifting. One we've heard that private health insurance premiums are going up because public payers are underpaying. And so that suggests that we don't have a cost problem. We have a revenue problem.

We heard not so much today but on Tuesday from Deborah Chollet, and actually a little bit today because of the MedPAC article that, in fact, cost shifting is a market failure and that it's a consequence of the market leverage.

And that Deborah said on Tuesday that the hospitals are revenue maximizers, and they will act in ways to maximize their revenues. So if they're in a competitive market, they can't shift costs. If they have market leverage, they can shift costs; and that, in fact, that market power is allowing some hospitals to be inefficient.

So we have these two different. One is that there's a revenue shortfall, and the other is there's inefficiency which is resulting in higher cost. And I think this is a debate that we have a lot with public payers in particular that the problem with talking about cost shifting is that it accepts that the underlying costs are reasonable, appropriate and efficient; and therefore, if there is a shortfall in covering your costs, it's on the revenue side and not on the cost side.

Nancy, I'm going to pick on you to talk about because this is an issue that MedPAC I think has looked at. The article that's in Health Affairs Today on MedPAC kind of makes this case. I think actually the AG found some of this as well, that there's actually explicit provisions in some contracts to allow cost shifting to occur. What do you have to say about that?

SPEAKER KANE: Yes. I think from the perspective of MedPAC, I don't know what's in the article because I haven't seen it today, but I know in our report in March and actually pretty regularly in the last couple of years, we've been trying to understand why some hospitals make money on Medicare.

We've looked at them and tried to understand how it is that if Medicare is such a terrible payer that people make money on Medicare. It looks like the No. 1 reason is they're unable to spend more and get it subsidized by the private sector payers.

So if you look at hospitals that make

money on Medicare and are actually relatively low cost relative to the national average, they have a non-Medicare margin of -5% on average between 2003 and 2007. So in other words, they are unable to cost shift because they don't have enough private sector, or they don't have the market power; or they have a lot of Medicaid. So they're just unable to make money on their non-Medicare patients.

The average Medicare margin for those providers is about break-even. So obviously, they've been able to live within the Medicare payment. That suggests that when you can get more money from the private sector, you spend that level as opposed to the reverse that you set your prices to cover your efficient cost.

The other thing we've tried to do, the staff has tried to do at MedPAC is understand whether these hospitals that are relatively efficient provide worse care. And we can't find any indication of that at all. In fact, if anything, it looks like metrics aren't perfect on quality, but the metrics that are available suggest that these hospitals that make money on

Medicare are actually quite high quality.

So there is at least from the Medicare perspective a very strong sense that the hospitals that don't make money on Medicare are basically because they're inefficient.

On Medicaid, which is a different subject altogether, probably Medicaid does pay less than an efficient hospital's costs. On the other hand, let's talk about where Medicaid comes from. Medicaid is a state, federal, taxpayer financed program. Most of our hospitals don't pay taxes, at least not property and not state income and often not federal income, and not federal income taxes.

So one question is, What is the quid pro quo for being tax exempt? Should you still get every penny that you spend back from the taxpayers, or do you owe the taxpayers a little something back because you are tax exempt? And you know, this is something I spent quite a bit of time doing trying to understand the relationship between the value of tax exemption and the value of what hospitals provide in benefit.

Obviously, people don't all agree on what benefits are. It's pretty clear that the Medicaid and the shortfall of Medicaid would fall into that type of expectation that impacted that hospital that you would expect. You should be actually maybe losing a little on Medicaid because you're tax exempt.

So one question is why do for-profits like Medicaid, they also provide quite a bit of Medicaid. So we're a little bit wondering where the value of the tax exemption is. So you know, in sum, it's not clear to me that the need to shift costs because you're underpaid as an efficient hospital is a good excuse for raising your rates to the private sector.

MODERATOR TURNBULL: Yes, Tom.

SPEAKER GLYNN: So I think that I'm following Nancy's argument, and I certainly agree with a good chunk of it. But I think if I say, well, 18 cents of every dollar that we charge Andrew is to make up for losses, that that is an order of magnitude impact on what the cost structure is.

I think if it were less, then maybe it

would be a little bit more of an argument. At the same time, I would agree with what both Nancy's are suggesting which is, Do we have a cost problem? Yes. Do we need to work on it? Yes. Are we working on it hard enough? No. So I don't think they're mutually exclusive.

I think it's possible that it is driving up costs and we should do something about our own costs. I would also say that it's tricky when you try to compare even among teaching hospitals, so I pulled some of this data because I thought it was interesting for purposes of this conversation.

So you know, we keep track because we always view ourselves as competing nationally and locally. So in terms of research dollars, we can compete nationally. In terms of attracting residents, we compete nationally. In terms of patients, it's more local.

So we keep track of what the other national institutions are doing, and we kind of use the U.S. News List because it's not a list we made up. So for 2008 fiscal year, BJC, which many of you know is in St. Louis, had an operating margin of 3.7 percent. Cleveland Clinic had an operating margin of 3.8. Johns Hopkins in a regulated state had an operating margin of 4.5. Penn had an operating margin of 4.8. Duke, currently run by a former Brigham & Women's Hospital chief of medicine, had a margin of 6.0.

MODERATOR TURNBULL: I'm sorry you let him get away, you know.

SPEAKER GLYNN: Partners, in case anyone wants to know how Partners fits into that, 1.7. People are able to do different things in different situations with largely the same portfolio of commitments. We think the 1.7 is a rather modest number. As Nancy suggested, people have been able to do different things in working with these same programs.

MODERATOR TURNBULL: Anyone wants to chime in?

SPEAKER LODGE: I guess the only thing I'd add is it probably would be helpful for us all to learn how these people are making money on Medicare and whether they are Massachusetts hospitals that are incorporated in that. I know that we regularly benchmark our total cost against lots of competition.

And we don't find anybody around here that's more cost effective than us. But it's just surprising. I'd love to see who can do it and how they do it, and if they can do it in this state in particular because there are different rules and regulations that apply here that may not apply in other arenas, that that may be different.

So understanding it, I think if this is really going to be a partnership, you ought to learn from those successes. If that's something that works and is transferrable, and God knows somebody ought to come out and educate us on how to do it because all of us every year for running whatever we're running, trying to manage our costs very, very effectively.

We think we do a reasonable job. We are responding to whatever the demand is in most cases, even though that's hard to do. Matching this up I think is maybe something you take away from this, how you educate people to make progress because I think we all want to be successful. If there's a track record out there that can do it, we've got a new consulting company.

MODERATOR TURNBULL: Andrew, you want to say something?

SPEAKER DREYFUS: We've talked a lot about cost structures. We haven't said anything yet. I just would like to introduce it that we know there's a lot of unnecessary spending in the system and that today under our current fee-for-service model, if an outpatient practice at one of Tom's facilities successfully manages a patient with chronic illness and they're not admitted to the hospital, the reward is that system gets paid less.

If that patient is admitted to the hospital and contracts a preventible infection, the reward to the system gets paid more. Clearly those incentives are backwards. So one way to think about how would we reduce the cost to the system is how do we create incentives to take what the clinical community has agreed is a lot of unnecessary harmful care. How do we take it out?

MODERATOR TURNBULL: I want to talk a little bit about disparities and payment. I think that's one of the most interesting things that comes out of the Attorney General's report and some of the Division work. Andrew, I want to direct this to you. Just to remind people, both the Division and the AGO study find these tremendous payment variations, cross providers that aren't related to quality, patient complexity, teaching status, disproportionate share hospital status.

I want to frame this in the context that we've been relying in Massachusetts and actually in the country as a whole over the last 20 years or so on private negotiations between health plans and providers to be a major vehicle for cost control.

As I think both Stuart and Paul observed that model for a number of years for reasons we could argue about, but we won't. It did result in some moderation of health care cost spending. But it's clearly kicked back up.

Andrew, I actually wanted to start with you. It's kind of on the health plan.

Particularly, you represent the biggest insurer in the state. You have more than 3 million members. I think that's about 60 percent of insured people.

If there's any insurer in the state who should have market power to negotiate with hospitals and physician groups, it should be Blue Cross. Yet, and Stuart said it's unfair, but through the beauty of Google, you can find things people actually said in the past.

In the Globe series back in December of 2008, the story says that you say that you shouldn't -- the Globe said that you shouldn't be blamed for the run-up in health insurance prices. You always try to cut the best deals possible, that you know that there are a number of hospitals that get paid more, but there's a limit to what you can do.

And you say you have to stay very attuned to the balance of the market, that you are not a regulator, that market fairness is a public policy issue beyond the control of any one company. So I guess I would say, do you or don't you have the market clout to be able to deal with the provider market as it's evolved?

SPEAKER DREYFUS: That was a very thoughtful comment that I made.

MODERATOR TURNBULL: I thought it was good. Your comments are always thoughtful, so you get quoted a lot. So the Google search was very long.

SPEAKER DREYFUS: To answer your question directly, and then I'll elaborate. I don't think we have the market power alone to eliminate the disparities that are displayed on that chart. I'm not sure if that chart is our rates or not. I think the disparities are very troubling, and I think they need to change. And the question is, How do you do that?

I think we heard from Paul, I mean, he was saying a lot of things I was thinking is that we actually have a mixed regulated and competitive system today. Half of the typical hospital's revenue comes from public payers whose rates are set; although, as I noted earlier, they vary pretty significantly. Then half of the typical hospital's revenue come from commercial payers.

We do work very hard to negotiate the lowest price we can possibly get. I would just, the same way that Tom suggested they look at national numbers, we compete with national plans; and benefit consultants, which advise national employers, are very closely monitoring the level of discounts that plans like Blue Cross can achieve. And we're constantly trying to negotiate the best deal.

As was noted in the earlier panel, there's not been much appetite in Massachusetts for broad networks, excuse me, for narrow networks which would exclude the hospitals either because of geography or reputation or brand or the array of services they offer, are required to be in most networks.

What I'd say has changed or just my thinking has advanced since I offered that quote to the Globe, which was probably 18 months ago at least, was the potential I've begun to realize through payment reform. I do think, and I was interested to note that the Center For Studying Health System Changes was just in Boston last week, and they heard it according to Paul Allot (phonetics) about our alternative quality contract which is beginning to assert a disruptive influence in the market.

I just want to give you one or two anecdotal examples. There's been a lot of talk today about what can we do with hospitals and what incentives are we to offer to consumers. There's not been much discussion on what incentives we can offer to physicians.

In fact, in most health care markets, it's physicians who are deciding where patients go to get their care less consumers. There's very few consumers who when getting advice from a physical, you should have this procedure at hospital X, will then intervene, look on-line, check out a list, check what their infection rates were and then change and override the doctor's decision.

Since we introduced our alternative quality contract, we've started to hear from primary care physicians who now have the kind of data that's displayed publicly here which we supplied to them, and they are beginning to understand the economic and the quality consequences of where they send their patients.

And they most often are beginning to choose to send their patients to lower cost, high-quality providers which should over time lower the cost of care.

So I think the disparity is troubling. I think it's hard for one plan alone to do it. I think it's time to think about what the proper balance of regulation and competition should be in the state. But we think that new payment models have to be at the center of it, whether you had a regulated system or a competitive system.

MODERATOR TURNBULL: Okay, we'll come back to that in a bit. Tom, do you agree with the AG's report that there's no correlation between price and quality care?

SPEAKER GLYNN: No.

MODERATOR TURNBULL: Okay. Thank you for that answer. Say more.

SPEAKER GLYNN: Can I say another word about what Andrew said before I turn to quality?

MODERATOR TURNBULL: Yes, you may.

SPEAKER GLYNN: So I think that again

kind of going back to the opening comments that Dale made, you know, I think you have to put these things in some perspective. I don't know, you know, a lot of times what's happening here is reflecting what's happening nationally.

So it is true that in the mid-nineties, the early and mid-nineties, the HMO's were successful in negotiating better deals. But it's also true that that was true all over the country. It's also true that the reason for that, as Dale explained, was we were getting 130 percent from Medicare. So we could afford to make these concessions.

So for example, when Dr. Theer (phonetics) was in Washington fine tune negotiating about the Balanced Budget Act, Jack Luge, then the head of the Office of Management and Budget under President Clinton said to him, you signed a bad deal with Harvard Community Health Plan. That's not my problem.

What was true was that the Brigham had signed a deal where Harvard Community Health Plan got roughly, I'm doing this from memory, so I may be off, a 40 percent discount on 25 percent of their patients.

So you know, we can look at that and say, wow, that's when the HMO's really had a lot of clout. Okay, maybe they did. But it's also true that the fact that Medicare was able to underwrite effectively these deals is not an irrelevant factor. Then in 1997, as we alluded to, the Balanced Budget Act passes, and the feds say, we're not going to do that anymore.

So they took away the subsidy that they had been putting into the hospitals that was making it possible for the HMO's to have this market clout. So you know, I think some of these economic trends are as important as looking at the political situation. So that's Point No. 1.

Point No. 2, I think if you take a step back and you say -- when you talk to people around the country about the quality of leadership we have in the HMO's here, they're quite surprised. A., we have one former head of an HMO running for Governor. I think this person who is the No. 2 under that person for many, many years is probably one of the most respected guys in the public and private sector in health care.

We have another health plan that's run by a prominent national democrat who's also been very successful running that company; and at Blue Cross, we have had a history of civic leadership running that company including now Andrew; in the past, Peter Mead; et cetera. So to me, to say well, these guys haven't had much ability to influence the market, I don't know.

Last, and most importantly, I just want to read from an article that was in the Globe on January of 2009 because I think it suggests that perhaps the pendulum has swung back more than we realize. So I'm quoting.

"The more recent Partners and Blue Cross contracts settled over the summer provides more modest increases, Partners officials said in an interview this week. The contract calls for increases in payments for medical services in the range of 5 to 6 percent a year which is roughly medical inflations, said Partners chief financial officer, Peter Markel."

So you know, I would go on to say, when we see in the paper some of these other increases, it's a little bit of a mystery to our physicians exactly how our contract is driving up these double-digit increases that we read about.

So I don't know if this situation is quite as sometimes it is characterized based on kind of my view of the history and kind of the situation that we're in right now based on what was said in this Globe article

MODERATOR TURNBULL: Actually, can I tell you one thing Paul Levy said about it this morning? Maybe you and others can respond about it. One thing he said about payment disparities in particular was that they've created a dynamic where more highly paid systems are able to recruit more doctors who then channel more patients to these highly paid places.

Is that -- Dianne or Dale, maybe first could you comment on that? Have you seen this happening within your community?

SPEAKER LODGE: Fortunately, no. But do we think that we are under pressures because some of the local physicians are being paid at a differential rate? Yes. And are we employing more physicians and probably having to underwrite that because of that factor? Yes, in order to retain things.

But you know, knock on wood, we're not losing physicians to just solely higher pay. Part of it is we've taken action to make sure that we develop a competitive both lifestyle and compensation, and we still manage our overall costs just about as effectively as anybody.

But it does create pressures, and we've had pressures on nursing salaries and other things because we're so close to Boston, and we do not pay Boston rates. We compete in a different marketplace. But salaries within Boston are significantly different than what they are in our marketplace. And that pressure is there for us to keep our employees there.

MODERATOR TURNBULL: Dianne, how about Lawrence?

SPEAKER ANDERSON: Yes, I'd say that is definitely a factor for us because I think our physicians -- we have sort of a mixed bag of physicians. We have a lot of small practices. Then we have some larger groups that have organized.

We have some that have joined up with

some of the IPA's of the tertiaries. There's a tremendous amount of competition. We know that we have probably somewhere around a 30 percent out migration from our area that goes, again, we're not that far from Boston, that goes, you know, into Boston primarily.

And these are largely cases that could stay and get the same excellent level of care in our hospital and with our physicians. So I think it's definitely a factor. And Paul's comment really resonated with me as far as the challenges that we deal with.

MODERATOR TURNBULL: Mark, how do you see this problem among those employers who are part of this program or the employee benefit folks, payment disparities?

SPEAKER GAUNYA: With all due respect to Dr. Ginsburg's comments earlier about consumer-driven health plans, I think he shared with the audience a very basic structure of a consumer-driven health plan. I tend to kind of peel away, with all due respect to my distinguished panel who's a lot more educated than I am and a lot more sophisticated with how they run their businesses, I'm talking with employees and employers everyday. I want to just kind of focus on one element, and that is the power of the consumer.

I believe the power of the consumer to be very strong in every industry, including health care. In fact, most estimates, and I'm not an economist, but consumers are the driving force behind a growing economy or a not growing economy. And the reality is until they get engaged in the health care cost discussion, until they get educated about what health care costs really are, and until they have responsibility to behave differently, they won't.

So I look at it and say, I ask the following question, and my clients are asking me this everyday, Why is it so difficult to share the price? Why do I have to find out about the cost of a service after I have it? Why when I call my doctor or I go visit with my doctor can he not tell me or she not tell me how much something costs?

If I want to go buy a car today, Mark, I'm not going to go do it today. I'm actually going to get on-line. I'm going to do research. I'm going to have all kinds of access to information at my fingertips using our wonderful technology you referenced, Google. Google, amongst other tools, can be and should be used by the consumers as long as they have the incentives to want to get engaged.

How I see it is I usually break a problem down to two buckets. Is it a mechanical problem, or is it a philosophical problem? So I ask the panel, Do we have a philosophical issue of transparency, No. 1? Do we not want to share? I know Dr. Ginsburg said if we do share, that could have the overall impact of raising costs. That could be a near-term problem.

I think a long-term solution is consumers actually getting engaged, asking questions and making informed and educated decisions and weighing out because they do have the ability to do this. They do in every other area of their life, cost and quality, to come up with a value structure for themselves.

So is it mechanical in a sense that health plans' contracts preclude them from disclosing price? Is it that providers don't want to say I'm charging $3,000 for this MRI when I know the next facility down the street is charging 500 for the exact same machine?

I had one client who asked me, what did it cost, I wanted to go to the bone marrow transplant place. I had a cotton swab done for my DNA testing. I got a bill from the insurance company, and it cost $4,300. $4,300 for a cotton swab for a DNA test. Why is that the case? Well, if the person had the information on the front end, maybe they would have made a different choice.

The question I ask, Is it philosophical, mechanical; or is it a combination of the two?

MODERATOR TURNBULL: Okay, Andrew, so is it philosophical or mechanical. You said in your comments you were concerned about a race to the top. You often hear that concern that consumers will, both that that will cause a race to the top in terms of negotiation, but there's also a concern I think that some people express that consumers in the absence of any other information will think that a more highly paid provider is a better provider.

And so that kind of creates a race to the top. I'd be curious actually after you finish your comments what Dianne has to say.

SPEAKER DREYFUS: I think everyone is -- I don't think there's a philosophical disagreement about the power and potential strength of transparency. We just have to be careful. While I agree, Mark, that that's the kind of ideal state we ought to work to, I still think that physicians often drive the decision, patient decision-making more than patients.

I am concerned about the race to the top. I have even in the last 40 hours gotten calls from a few hospital officials who are curious about where, you know, the race that appeared in the Attorney General's report; and perhaps in some ways that's a good way to churn things up.

MODERATOR TURNBULL: And we want to negotiate them down.

SPEAKER DREYFUS: I haven't gotten that call, Nancy. I've been waiting for that call for five years. So I think there is a concern about that. I think ultimately we do have to get to this value question.

I think one of the things that we are increasingly experimenting with, and it deals with both the MRI question Mark just raised and the other, is exposing consumers more to those places where they can make those decisions.

I don't think if my father needs to go to the emergency room, he's not going to sit around. He doesn't even own a computer. He can't get onto a computer to make these decisions. He's going to go where he's comfortable going, where he's used to going, where the ambulance is directed to take him.

On the other hand, we pay $700 for an MRI in most free-standing facilities, and about 1,400 when they're on a hospital campus or a hospital outpatient facility. I understand that hospitals will tell us that they have other higher costs that get built into that price. That seems like a big differential.

I think we need to design products increasingly where consumers have an option and if they want to go to a higher priced facility that they bear some of that responsibility. Actually, at Blue Cross, we now, that's one of the plans we offer to our own our associates. I'm in it. So I'll give you a report at the end of the year how it's going.

The differential is substantial. The difference between going from that first tier hospital to a third tier hospital is hundreds if not thousands of dollars. So we need to experiment with those products. As I believe Jim Roosevelt said earlier today, there's not been a great take-up. But we've seen a growth, for example, in our new tiered product from about 10 or 15,000 members to 50,000 members in the last quarter and a half.

SPEAKER LODGE: I'd add, I believe everything that you've said as long as the consumer also has to pay some of the differential, just not knowing the price. By the way, could I get that $1,400?

SPEAKER DREYFUS: There they go again.

SPEAKER LODGE: I just thought it was a good idea.

SPEAKER ANDERSON: I really find that

it's inexcusable really that our hospital and our physicians would be paid significantly lower rates for the same procedures. And we want to hold ourselves accountable as far as quality and transparency.

We're working very, very hard to do that. But it's just, it's hard to understand why without any other basis as far as quality outcomes or other key factors, why that isn't true. We're not even asking to be paid as high as Partners, but at least maybe Winchester. It just doesn't really make any sense.

I think that for the patients in our area, if they knew the price, and it did make a difference to them as far as what they had to pay, and they had all the information as far as the difference in quality for the physicians that they were going to and the hospital that they would probably make wiser choices if that's how the system was structured.

MODERATOR TURNBULL: Okay. We have actually a couple of questions related to this. So this one is to the providers. Are you willing to provide true transparency to cost of care and the quality to the public? The public can't engage in the cost of their care and responsibility of their care if they have no idea of how much things cost.

And then Andrew, a challenge to you. Is Blue Cross Blue Shield a market dominant payer? Do you think you have an obligation to your members to educate them that your payments vary wildly, that your payments don't reflect quality? How do you justify this dramatic and until recently secret price disparity to providers?

SPEAKER LODGE: So can I try the providers?

MODERATOR TURNBULL: Please do.

SPEAKER LODGE: One of the discussions, I haven't gotten to listen to Barbra Rabson this morning, but at another meeting on different measures of quality. Quality is, there are all kinds of different measures out there. If we could somehow start to standardize what are the quality measures, you know, across all payers and what everybody is interested in seeing, then I think you'd have an effective tool that consumers could evaluate far more effectively.

But your gut is each insurance plan having their flavor of quality. MHQP which frankly is an independent body, which said to me it's a good set of quality. There's someone doing it on an independent basis with others. If we could have one set and people could focus on that, because the truth is measuring quality in a hospital, you could have thousands of different measures that no one would really be able to understand.

Frankly, most of what's out there is mostly process oriented and not outcome oriented yet. I do hope some day it becomes more outcome oriented. And lastly, you know, our -- I don't think we have any trouble posting our prices and letting our prices be out there and be transparent out there.

I have no arguments with anything that has been published to date. I think our prices are competitive and fair, and so I don't think there's any issue. The fact is if consumers were engaged in doing price shopping, I think as an organization, we would do extremely well. So we wouldn't have any problem at all of having it posted out there.

It may not be true of everybody. We'd like it to be out there. We'd like those differentials to be identified and actually have whoever is choosing it pay the difference so they can start to pick things more on price and whatever quality measures we come up with. I think that's a good step with everyone

MODERATOR TURNBULL: Andrew, do you think you have an obligation to make your payments public and say they're not related to quality?

SPEAKER DREYFUS: First of all, I would challenge that they're not related to quality at all. I agree with the overall point that the Attorney General made that as a general rule, they're not.

But what we've been trying to do increasingly is tie our payments to quality, whether that's through pay for performance programs or especially our new alternative quality contract. That was the whole piece, the whole point behind it was to both moderate the growth in costs and to try to improve care. The way to do that is to focus on payments of quality.

MODERATOR TURNBULL: What proportion of your payments are related to quality?

SPEAKER DREYFUS: I'd say it depends on how you define it. In the alternative quality contract, it could be up to 10 percent of those payments. It's a little bit less -- one of the challenges here is there aren't wildly accepted quality measures for a whole range of illnesses. Let's take cancer for example. There aren't yet the standard set of measures around quality care for cancer that we could link payment to.

Back to the original point of the question, Do we need to be more transparent about this? Yes. We'll actually be over time giving our members on-line tools to help them understand the cost and price of care and the consequences, especially within our new products of choosing different tools.

I would also say that more than half of our customers are self-insured. And while they're not posted on-line, we're paying claims for them which they get to see. And so they're acutely aware of the prices that we pay for care and constantly pressuring us to keep them down.

MODERATOR TURNBULL: Lois, you have a question.

MS. JOHNSON: Just a follow-up question about the AQC, and we hope to learn more about that particular model. In terms of going forward then if your interest is to tie payments to quality, when you set the budget for the AQC, are you looking at historical quality performance; or are you just talking about going forward and sort of measuring the prospectively tying some payments to quality? But when you set that budget, are you setting it based on quality performance?

SPEAKER DREYFUS: No, you're absolutely right. It's going forward. So what we tried to do, and we could go into as much detail as you're interested in, one of the key decisions that we had to make when working on the AQC is to try to distinguish it from change what didn't work with past capitation models. Part of that was there an attempt to reduce payments at the beginning.

We made an attempt to try to start, to start people where they were, to try -- we didn't think we'd have any luck getting people to accept a quality based contract if we said the first thing you'd have to do is reduce the cost. So what we do is we estimate at the beginning what their quality performance is today.

How much additional payment that would generate for them and then show them the potential as they improve their care over time how they can earn more in quality. At the same time, they make a commitment to reduce the overall cost of care, the trend that we're so focused on here over the course of the five years. Most agreements are five years. In most cases, we're asking them to cut the medical trend in half.

MS. JOHNSON: If as we've seen with respect to the overall trend it could be as much as 75 percent, but depending on how you parse the taxonomy of medical trend, at least 50 percent of that is price, how does global payments or in the AQC version of it moderate price over time?

MODERATOR TURNBULL: I guess part of it might be in terms of talking about part of what we're talking about today, what might the premium impact be of the AQC?

SPEAKER DREYFUS: We have 25 percent of our members right now who are affiliated with primary care physicians who have chosen this form of payment. To the extent that over time, A., we can design products around those caregivers, and to the extent that they are successful as we hope and as they're designed to reduce the rate of growth in half, then that will translate into lower premiums for those employers whose employees are participating in those contracts or who we hope over time will buy products that are organized around these set of providers who have made an agreement at the beginning to reduce the rate of growth.

I think underlining your question is a deeper question which is, Is there a potential for the alternative quality contract to lock in existing price structures and payment disparities? I think there was a potential for that which is why it wasn't something that was probably appropriate for some higher paid or higher priced providers in our network.

What we tried to do and to the extent that some of the providers who entered in this early made deeper commitments to bring their costs down, we're trying to move our providers towards a network average. But again, we didn't want to have them re-experience the perils of capitation where physician practice has lost money right at the beginning. I don't know if that's getting too granular.

MODERATOR TURNBULL: I want to shift gears. Actually, I want to come to a different issue that was talked about in the AGO's report; that is, the impact that expanding the footprint of the academic medical centers is having on cost.

The same scenarios where there's a tension in the system between the business interests of individual providers and perhaps what's good for the system as a whole in terms of costs. Paul talked about this a little bit this morning when he talked about duplicative services and things.

Tom, if you could talk about just as one academic medical center to help us understand what some of the business imperatives for Partners and other academic medical centers are expanding into the suburbs? Are there capacity shortages in the suburbs you're trying to address? Is there crisis of quality? Are there scale economies that you get by expanding?

SPEAKER GLYNN: Well, I think that you have to start with kind of the patient's experience. So let's pick on Danvers as an example because a lot of people are probably familiar with it.

So North Shore Medical Center has two campuses, one in downtown Salem and the other one in a residential neighborhood in Lynn. The Salem campus is quite old. And in fact, it may be one of the few remaining campuses, Dale may know more exactly, of community hospitals in Massachusetts or in the region, it may be one of the few hospitals that up until extremely recently had quads, which are rooms with four beds.

So we're pretty confined into the space that we have there, and in the same theme with the residential neighborhood in Lynn. So we had already had two satellites that had been established by Salem Hospital, one for cancer and one for women's health.

So the notion was to try to expand those two centers kind of in one location and make it more convenient for people who are trying to get either Salem or Union Hospital. We picked Danvers. We picked Route 128 because of the accessibility issues.

It's also the case that, you know, if you go back over the 25 years, there were a lot more patients now who need to be treated with either radiation therapy or chemotherapy who require kind of short stays. So the kind of models that we built in these campuses 30 years ago of inpatient stays and visitors doesn't really fit a lot of people coming in for short treatments and then leaving. So you need a different kind of a model. That did not lend itself to either the campus in Salem or in Lynn.

So that was really I would say more of the major focus of why we undertook that. You know, I think that there is a concern that both of those campuses serve most of the low-income people on the North Shore. And so it was an effort to try to make sure that we were getting a reasonable patient mix at the end of the day since we've been subsidizing both of those places pretty much, since shortly after it came into the system.

So I would say those were kind of the two main factors that, as I remember, this is a decision we made five or six years ago. So I may not have a perfect recollection. But I think that's kind of an example.

MODERATOR TURNBULL: Was that the same, for example, in Foxborough?

SPEAKER GLYNN: Well, we might as well go around 128. So you know, in Milford, there was a joint venture done with the Milford Hospital. It's South Shore Hospital there was a joint venture done with the South Shore Hospital and Dana Farber.

In Foxborough, that is an area where there's population growth unlike the rest of state, and we were asked to take a look at an opportunity because of the fact that Foxborough is kind of in the middle of several other service areas. So we decided to try something that we hadn't tried before which is open up a facility and try to serve the people in the southern part of the marketplace.

Historically, the Brigham has had a pretty healthy representation of people from the south. I forget the exact number, but there's a decent number of people who are being served at the Foxborough facility who used to be served at the Brigham. I just don't remember off the top of my head.

MODERATOR TURNBULL: Andrew, when that happens, when they're expanding a footprint, what impact does that have on your premiums? Are you paying at teaching hospital rates? So what's the cost impact of those?

I'm curious if Blue Cross has ever thought some of these expansions or investments were not needed? Have you ever said that you wouldn't pay for them? Have you ever made any attempt to stop this through your market power?

SPEAKER DREYFUS: First of all, I would say that those questions have been a point of great, intense negotiation in our negotiations with systems like Partners. And by the way, there are other academic facilities in Boston that are doing the same thing.

MODERATOR TURNBULL: Yes, Tom got to have a seat today, so.

SPEAKER DREYFUS: Right, and there are others doing that. I think we're very concerned if there's an attempt to charge what I would call academic level rates which are higher for a variety of reasons, some of which we've noted, and some of which we've because there are a variety of costs built into more complex organizations and community facilities. We've tried to fight that very strongly.

MODERATOR TURNBULL: How's it gone?

SPEAKER DREYFUS: Some success. I also think this is an area, you know, we haven't talked much about back to the balance of regulation and competition. We've not had a very strong voice in health planning in the state. We've not had a very strong certificate of need program for a number of years. I think those programs have to come more into play as we think about what are the best resources in the community.

MODERATOR TURNBULL: So Dale, has the, have some of these expansions effected Winchester? If so, how?

SPEAKER LODGE: Not on volume of patients for us right at the moment. We have lost staff to, because in fact, you know, Boston rates come out to the suburbs. And you know, people either choose they want to work in Boston, or they want to work in the community. We have lost staff, and we lost some significant staff initially.

It kind of balanced off over the years, but that's probably been the immediate impact on us directly. I know other community hospitals are seeing a very different story. They're losing volume to, I mean, let's face some reality here, Mass. General and the Brigham & Women's Hospital have absolute fabulous brains, and there's no question on the data about that.

When they come out into the community, they bring that brand out there. That does attract patients, and it competes directly with community hospitals. Knock on wood, we haven't seen it personally at Winchester. But I certainly hear in anecdotally from other local community hospitals

MODERATOR TURNBULL: Julie, you're shaking your head.

SPEAKER PINKHAM: Because we represent 70 percent of the hospitals, we're seeing nurses on both sides of the issue. So there's no doubt that the opening of an institution up in Danvers by Partners is beneficial in terms of the North Shore, but it did have a negative impact on Northeast Health Systems.

I mean, so on the one hand, we're growing in one area, and the other hand, as nurses, we're sitting down and realizing that they're probably going to shutter that institution. The wages were less at Northeast than they might otherwise be.

At the end of the day though what I find ironic is I'm not interested in throwing Partners under the bus because most of the time you're probably looking to pick up hospitals that wouldn't survive. Most of the reality is that's the model. I don't know that we can demonize the success because that's the model. It's a competition model.

I don't think any of us were frankly surprised. We literally sat down as an organization when this started and got groups together and took the geography of Massachusetts and said, I'm going to tell you right now, these hospitals are going to merge, and which networks are they going to go with. And we're continuing to do it right now.

I think the bigger question for us is when is it going to stop? I do agree with the DON, whoever raised it here --

MODERATOR TURNBULL: It wasn't Tom. It was Andrew.

SPEAKER GLYNN: It wasn't me.

SPEAKER PINKHAM: The question, I guess it's not, you know, that's the model. If they can build a facility and whatever, that's fine i guess. But the question is, Do we need it, No. 1? And what's its impact with surrounding institutions?

We don't actually have an assessment of health care needs in the State of Massachusetts. We close a facility, and we don't know whether or not that's in the public's best interests at all. If that ER shuts down and my heart attack now puts me at a higher risk of death, that's troublesome to me. That's not really the discussion here.

I guess in the transparency of information, I think it's a great thing. But the general public isn't going to go on Google and even understand half the language that's there. They want to know exactly who you know and where you've been to, to what facility. The public relations stuff that is out there, the media dollars that are spent right now, an incredible waste as far as we're concerned. That is driving the public.

There's less effort on transparency and data than there is on billboards, television ads and newspaper ads, and I think that's definitely driving the population into certain services, you know, the Davinci billboards and whatnot. I mean, these are the things that I think in health care are part of the cost drives as well.

But the people that are utilizing the system to the success of the system aren't the demons. It's the policy, itself, that's problematic. And in the meantime, I think right now as long as if one hospital shuts down, one more hospital shuts down, these community hospitals, I don't think we're served well at all.

We shut down 30 after we deregulated, and I understood that we were over-bedded. I guess that's a glowing success of competition to have set down 30 hospitals, and Worcester which was eight hospitals is now two hospitals. That's driving up costs without an assessment of actually health care needs to the public.

If we see Quincy Hospital, North Adams Hospital, Jordan Hospital, Milton Hospital, we can't afford to lose these hospitals. And I guess why the debate goes on, including Lawrence, which I agree on some of the issues they're facing. We represent the nurses there.

In the meantime, if we can't find a way to hold on to these community hospitals, if any one of those close, we simply have done a disservice because it will drive up costs.

MODERATOR TURNBULL: Nancy, you came of age as I did during the time of state health planning. Has the horse left the barn, or is there something that state health planning could contribute to?

SPEAKER KANE: Actually, there are some

states that are quite a bit less engaged in controlling the rate of increase of new facilities and owners into their health care markets. And I'd say some of them are really suffering for that, particularly the states that have had a lot of venture-backed specialty hospitals like heart hospitals and ortho hospitals.

They just come in and siphon off the most profitable patients and leave the community hospitals with less profitable patients. I would say the community hospitals in those markets have shown remarkable resilience in their ability to find other profitable services and raise their prices.

So the hospitals survive perhaps, but the affordability of the system doesn't do so well. So I think it is probably, Massachusetts is still relatively more controlling than other states. But I think, you know, since we don't have a -- I'm not aware of a more highly regulated state that does control access more.

I can't say that that would be better or worse. Probably some thought going into -- I remember years ago working with the state around

St. Margaret's closing. And it served a very useful community purpose. But it just didn't keep up with the, it wasn't competitive on a variety of dimensions. They didn't have the time to keep up by the time they realized they were going down. And I think that probably damaged the community.

The next closest option for the types of services they offered was in Brighton, and they were in Dorchester. That's not exactly an easy commute for a teenage pregnant child, girl, person.

I think there are a lot of community things that you'd like to have raised. You'd like to have a public conversation about them in some meaningful way. I think that table has been sort of shrunk and removed; and the idealogical fervor of government is bad, that probably isn't very thoughtful. And I think we should probably reconsider those removals of constraints of just letting anybody compete anywhere.

I do recall the comment of one of our state politicians about when we switched from having a more regulatory all payer certificate of need dominated system to a competitive system, Senator Burke I think it was said let's just put all of these scorpions in the bottle and put on the lid. That's how we lost 30 hospitals. That's how we allowed more expensive hospitals to beat up on the less expensive hospitals. And that' probably has not helped overall our affordability.

MODERATOR TURNBULL: A lot of questions from people who are here about global payment. So we've heard a lot I think today, and on Tuesday in particular, about the need to rationalize payment. A couple of speakers on Tuesday talked about the irrationalities in payments regardless of payment method.

And one of the things that I found was interesting about the AGO's report was some of the highest paid providers in the state are actually ones who are paid on global payment. And so one of my take-aways from the AG's report is that market leverage trumps payment method.

And I think some of these things were a surprise for those of us who don't look at payment things everyday. We heard this morning, we'll pick on two, Atrius and Fallon have the highest health status adjusted total medical cost in their geographical areas.

Why isn't this the power of global payment? What's the design flaw, I guess, at the moment in terms of how we're doing this that's causing these integrated globally paid systems to remain so expensive even though they have very strong financial incentives presumably to want to be as low cost as possible?

I guess there's a distinction here between being highly paid and being low cost. You're going to get me for it. So I jumped in before. Conversely, what's interesting, is some of the lowest cost systems are paid on a fee-for-service basis.

So I guess, what did we learn from these kind of counter-factual things about, as we move forward going towards payment reform?

SPEAKER DREYFUS: Do you want me to take that?

MODERATOR TURNBULL: You can start.

SPEAKER DREYFUS: I think we learned a lot from it. One thing we learned is that the older risk deals that were the subject of the Attorney General's analysis were not particularly useful in slowing the growth of costs or improving quality.

They were just a different way of paying that worked for those particular groups. But I think the evidence suggests that they did not have a significant impact. I think it resulted in different organizations of care which may be useful as models for the future. But I think -- again, I hope that when the Attorney General takes a fresh look, let's say, a year or two from now when we have more results from our alternative quality contract, they'll see that the rate of growth with those groups within the contract are declining at a time when the fee-for-service rate is increasing and that that will be an important statement about the potential success of this model.

Again, I think the reason why it's somewhat counterintuitive going forward is what I suggested to the Assistant Attorney General earlier that we had -- in our own thinking we had to decide how do we entice organizations into a new payment model that actually anticipates their overall trend going down relative to our network as a whole, relative to business as usual?

And the only way to do that was to start them close to where they were today. In some of those cases, those were organizations that had higher, had higher prices; in some cases, lower prices.

And so it's a new model in that respect. Again, I can't emphasize enough how often we've seen in a very short period of time referral patterns start to change within these organizations. Some of these issues, we hear about Lawrence General, we hear about Winchester, have already begun to change because the physicians understand that if they keep their patients locally that the overall cost of the care will be lower; that it will be more integrated, more seamless, more coordinated for the patient and the system as a whole will benefit.

So I'm very optimistic about that. We'll have to see what the results are. We don't necessarily think that our model is the answer.

We think it's an answer. We think it's important to try. We've seen this begin to disrupt long-standing relationships in a positive way, and we hope it will start to reverse the trend.

SPEAKER LODGE: I just add, since you're starting it, under it, history, and I believe Robert Gannett (phonetics) from Brandeis is here demonstrated that throughout the company global payment and integrated payment systems absolutely reduced overall cost trends. It's really counterintuitive, that a integrated system that is actually primary care driven would be one of the higher cost systems. It doesn't make any sense.

Frankly, I've managed groups. I've managed groups under physician groups and hospitals under capitation that have significantly reduced costs. So that even in our beginning parts of this, you can see decisions that are being made that will definitely make a difference in the overall total medical costs that are out there.

It's not a perfect system. I'll go back to my advocacy that it's not just about the provider payment. It needs to be a partnership between the products that it designs and the consumers who participate in them that they completely understand what they're getting themselves into.

So there is a higher level of compliance rather than just providers being the only force in making this change. But it certainly changed in history, and even the beginning parts of revisiting this seem to be having some early-on successes.

It's how it gets supported in the future because the truth is it does need to be more managed, and those primary care physicians need to be given more time to actually manage the care. And rather than living on, I got to see 30 patients every single day, I've got to take some time and really think about how I'm going to manage the care of this patient overall. It's a very different animal than a fee-for-service. But it is surprising to see those discrepancies.

MODERATOR TURNBULL: Nancy.

SPEAKER KANE: I guess the one way I would interpret those discrepancies is that's what the payer negotiated. It's not necessarily their cost structure. So we don't really know if they would have been more or less efficient under a fee-for-service. The other thing about Atrius, I'm less familiar with Fallon, but Atrius contracts have some of the most expensive systems.

SPEAKER LODGE: That's also correct.

SPEAKER KANE: So it's hard to tell again what the benefits of being integrated on a payment basis when they're still paying out fee-for-service to some of their provider network. But I agree that some of the better integrated systems that have the insurance function merged with the delivery function really are incredibly efficient and much lower cost than other, more fragmented delivery systems.

SPEAKER ANDERSON: I'd just like to comment that we don't have an AQC model yet. You heard earlier that we have a relatively low private payer populations at this point. It's something we're interested and we're trying to prepare ourselves for.

I have two major issues. One is would it lock in the price disparities that we already have and we're already, clearly have been spelled out? And then also, I think we heard from Dr. Spivak from Mt. Auburn and the other panel, to be effective in these models, you have to be on the right kind of approach to be able to manage it, the right infrastructure, information systems.

That in itself takes additional resources that right now as far as our rate structure, all of those factors are not built in

MODERATOR TURNBULL: I should probably ask a sort of follow-on question to that which is that and a little bit more. So those of you who were here on Tuesday heard Len Nichols talk about the need for what he called creative antitrust people I think he said as a way to create -- he was talking about it in terms of countervailing market forces to providers with market leverage.

One of the things he suggested was with creative antitrusts, people that -- there would be a benefit to the system from a cost standpoint in having payers share information, share payment methods.

But you can imagine actually picking up a little bit on what Dianne said that there are tons of areas where if health plans were to collaborate instead of compete with each other, that there could be cost benefits for providers for patients for the market as a whole? And these could range from payment methods to I think helping to collaborate on some of the types of administrative care management investments that need to be made to providers, quality improvement, quality measurement and management.

Attorney General Coakley was asked a question after that about whether the Attorney General's Office would be willing to engage in conversations about that. Andrew, I guess, would Blue Cross be willing to do that? Do you see opportunities there? Have you ever tried?

You're under oath, so I guess you can't -- I mean --

SPEAKER DREYFUS: First of all, I think there's tremendous opportunity, and I think we would welcome the Attorney General's involvement. Even while I'm under oath, I can say for example that in this area of quality measurement that we ought to have a consistent set of measures that the plans use.

By the way, I would not just focus simply on the private payers. I think the public payers have an enormous responsibility here. Lawrence General Hospital which has such a high percentage of its patients paid through the Medicaid program, if the Medicaid program moved to a global budgeted payment system, then Lawrence General Hospital would be much more ready to accept global payments from private and commercial payers like Blue Cross.

We're also hopeful that our form of local payment would be successful enough in the current market that actual providers will approach the other payers and ask them to pay in this form because it's successful and it's letting them thrive, improve quality, letting them put the primary care patients, the primary care providers back at the center of care where they ought to be. We'd be very open to conversations with the Attorney General's Office about collaboration on a range of issues.

MODERATOR TURNBULL: Where do you think there's the most potential to get both long-term and short-term savings? You know, one of the things lots of people point to as a source of rising costs is health plan administrative expenses.

Although you pointed out and other people pointed out 90 cents on the dollar, it is still the case, and I'm probably one of the only people in the state who slogged through the financial filings for the plans, that health plan administrative expenses have been going up until the last year or two at pretty much the same rate as medical expenses, you know, far surpassing increases in wages or overall CPI.

So you said that Blue Cross has been engaged in a variety of efforts to take costs out of the system? Why are they going up so fast until now? We do want to focus on areas where collaboration could reduce the huge amounts of administrative costs and complexity, not only for health plans but for providers and also medical expenses. Tell me the top couple of areas where we might be able to get some big wins.

SPEAKER DREYFUS: I think the big wins are exactly where I thought you were going which is in terms of administrative complexity and simplification. While it's true that 10 percent of the premium dollar supports health administration, we understand that our requirements cause a lot of administrative spending in the delivery system.

And if we were to simplify our requirements and/or standardize them across plans, I think it would cause a lot of savings and perhaps, more importantly, cut down a hassle factor; for physician practices especially, but also hospitals, experience.

So for example, there is an existing effort where we've centralized credentialing of physicians in a single organization called Health Care Administrative Solutions that actually is housed and supported by Blue Cross, but the other plans participate.

I think there may be opportunities to dramatically expand the portfolio of Administrative Solutions that that organization or the health plans together can do. So I think there's a great opportunity there. And I think it would be welcome by the physician and hospital communities that have to hire sometimes an army of staff to deal with competing regulatory and administrative requirements for both health plans and government.

MODERATOR TURNBULL: Hospital people, does that sound like that would make a measurable difference?

SPEAKER LODGE: I think it would make a world of difference. I'm trying to think, and I was walking in with somebody talking about the number of people that we've had to add to track all the different quality initiatives that are out there right now.

It's astronomical. It's not just the people who are doing the data. It's nurses actually who like having doing care having to chase a lot of this data. Let's face reality, if you're going to get paid for it, you're going to make every effort to make sure that you do those things.

My advocacy this morning with Barbara is somehow if there could be a collective that came together and said here's the 15 most important quality indicators that you ought to all pursue. Whatever incentives are put into any one of these deals, they're all kind of focused on that. They have the best outcome out there that really standardized it.

The products, I don't remember the exact number, thousands of Blue Cross products existed historically. Someone shows up with a Blue Cross card -- basically, it's a Blue Cross card. Who knows what it really represents in the end and just trying to figure all that out, maintain all of that, whether it's at the health plan level or the number of billing people you have in your office trying to chase all of this, there have got to be opportunities there.

I'm not saying they're not value added. But in the end, they're not reducing infections. They're not reducing falls. They're not focusing on things that we really are all about in the end. I don't see them as things that distinguish Blue Cross versus Harvard Community Health Plan versus Tufts and not processes that make them something better in the marketplace.

So if there's a private, I think Glen Nichols said if you do this private public thing and somehow get around these antitrust laws, it will eliminate some of the hassle factor for a lot of people, you can really streamline a lot of things. I'm very optimistic that something could be done.

MODERATOR TURNBULL: Tom.

SPEAKER GLYNN: I think I would adjust a couple of things. One on the quality front, I agree with everything that Dale said earlier about the numbers of over 100 different public measures that we're trying to keep track of. In response to what Andrew was saying about administrative complexity, I haven't checked this recently.

This was an anecdote that I had discovered a couple of years ago when I was in a discussion with Charlie Baker about administrative simplification. At that time, the Partners billing office had about 450 people sending out bills. Of the 450, 270 were doing rebilling of health plans because the first bill was rejected.

Now, you know, we can have an argument about whether or not it was the right number, but that's a big number. Even I would say 270 times an average is a significant amount of expense.

In the conversation, Charlie's part of the discussion was to say he had 1,500 different accounts, and virtually each one of them had a different plan because, you know, somebody wants a $7.50 copay, somebody else wants an $8 copay. This kind of tailoring, which means he has to keep track, and we have to keep track because when a copay comes in, you have to remember, you know.

So there is a big opportunity there. I think there had been some efforts, as Andrew indicated, to try to get ahead of it. More is better. Because it would be a lot easier to try to move some of these other things if people weren't so frustrated with the day-to-day operation of the system.

MODERATOR TURNBULL: Mark, I want to ask you, and anybody else who wants to talk about it, a question. And that's about the role of employers as a force for cost control in Massachusetts. Now, we know employers are by far the biggest payers for private health insurance here in the U.S.

But in our state, and I think in a way

that's a little bit different in many other states, they often seem to be missing in action when we're really talking about cost control. And we have an I think really complex political environment in this dynamic in the state because so many of our largest employers are either providers of care or health plans or biotech firms or pharma firms.

In fact, if you look at the boards of the major employer organizations in the state, most of them, not all of them, but most of them have lots of providers on their boards. One of them is chaired by a top official at one of the academic medical centers. One of them was recently chaired by the head of one of the academic medical centers.

It's the same thing as the health plans, big employers. On the one hand, this isn't surprising because, I mean, as Tom mentioned, we have very esteemed people in the provider community and business community. There's sort of a level of intersection here because of what our economy looks like. I think it's really quite different than in many other states.

It seems to me this actually creates some immense conflicts of interest for employers in terms of thinking that employers will get involved in a robust way in needing to control costs.

So I guess I'd love to know from your perspective, do you see this as a hindrance to our ability to control costs? Is there some way to, you know, re-point employers towards cost management? Should we give up because we are just, given the structure of our economy, we're never going to be able to do it? How do we deal with what's to me a huge conflict?

SPEAKER GAUNYA: How I respond, I think your characterization of an inherent conflict of interest is absolutely there. It used to be that it was discussions that happened individually, and there wasn't so much crossover between organizations.

I think ultimately when you start getting away from policy and start looking at politics, which inevitably happens when you have a conflict of interest, you can't make the tough decisions. Sometimes the tough decisions are painful for everybody.

So I go back to the philosophy of transparency again. Do we have a system that's transparent where we know health plan executives are sitting on the Boards of providers, and provider executives are sitting on the boards of health plans? Is that transparent enough for everybody to see for those conflicts of interest?

You had us raise our right hand and asked us a second question which is to ask do we have any conflicts of interest with our testimony today? I think if we could again provide transparency at the health plan and provider level of who's serving on whose boards, then perhaps you could have real dialogue about changes that need to be made.

As it relates to employers and getting involved in the cost game, my colleagues and I talked to employers. We happen to be the deliverers or, if you will, the messenger of the bad news. I go out every, single day, and I'm talking to employers, CEO's CFO's, HRVP's, and more importantly, the rank and file who ultimately are provided with the insurance product that their companies choose.

They're frustrated to no end as to why health care costs rise. But if you get an employer to understand that they are part of the challenge as opposed to the victim and get them engaged in the principles of how we can solve this challenge, which is to say you need to engage your employees in a discussion about transparency of cost and quality, you need to engage your employees in the principle of responsibility, that they have a responsibility to live a healthy lifestyle and to make informed purchasing choices.

And just to clarify one point about transparency, nobody's expecting anyone when they're in the hospital bleeding profusely to whip out their laptop and make an educated decision about where they're going.

MODERATOR TURNBULL: That's news to me.

SPEAKER GAUNYA: But the lion's share of emergency costs are not in those health care areas. There are other things people can be doing about other areas of health care where they can make informed purchasing choices. I don't disagree that it's complicated.

But if we can save lives with the technology and know-how we have, I think we could boil down our health care language down to language people can understand. So I reject the notion that it's too complicated. That's frankly the role that people like me play everyday.

While the policymakers are doing their things, the providers are doing their thing, the employers look to us to say, okay, here's what I can afford to buy my employees. I want to be on the leading edge so I can attract and retain my employee corporation.

I care about my employees, so I want to make sure they have the best available coverage that I can afford to pay for. Now when you work with me to pick out that solution, now I need you to help educate my employees.

One of the things you brought up, administrative costs, a few minutes ago, brokers and consultants are often looked at as a source of savings potentially in the system of eliminating us from the equation. I will share with every one of you right now if we are eliminated from the equation, employers would lose their minds.

And what do I mean by that? We are the objective source of information of evaluation of all the options. Once an employer picks a health plan, we are also the people responsible for educating their employers. All the while, we're helping employers understand how to stay in compliance with government regulation. And God knows, that continues to grow.

So we have a daily effort to keep them in compliance with the law so they don't fall out of compliance. On the health plan side, it's to say, okay, to your point, I have thousands of different options, or maybe hundreds in this case, how do I evaluate what's best for my dollar and give my employees the maximum benefit for the dollar I'm spending? Then once I do it, are they going to understand what it is they have to do?

I do think employers can be engaged if they ask the question philosophically where do they sit on that level of I want to engage my employees, or I don't want to engage. If they do, they absolutely can change their cost perspective. If they don't want to, then they won't change it. But I do think going back to the original point of your question that there is inherent conflict.

In fact, I was at an advisory council meeting this morning with an unnamed carrier, and it came up, this whole issue of conflict between provider boards and health plan boards and are people not willing to make the difficult decisions because of that inherent conflict?

MODERATOR TURNBULL: Anyone else want to respond to that? No. Just one other not entirely related, but somewhat related question. As I've sat here over the last day and a half and as I've kind of watched health care in the state for a long time, but particularly now, there's two conflicting stories about health care's contribution to the economy.

In particular, right now as we're talking about costs, we're hearing these tensions come up. One school of thought or argument is that we have to be really cautious about controlling health care costs because health care is the economic engine of the Commonwealth. And we know very predictably one of the things that people will say whenever we talk about controlling costs, and it always comes up with spending controls that it's a job killer bill. I think that has particular resonance now in the economy.

The other opposing argument which we heard really eloquently from the Senate President, the Governor and others is that rising medical costs are killing economic growth in the state, killing the job creation. The Senate President said that controlling health care spending is essential to the long-term economic growth of the state. It's also attention that's been playing out for however long national health care reform has been playing out recently.

And President Obama has really I think tried to make the economic imperative to control health care costs the central rationale for why we should have national reform. We even heard it on a personal anecdote from Eric Michaelson, owner of Michaelson's Shoes who talked about how he liked to hire another worker, but the cost of his health insurance is making that impossible for him to go.

So I find myself sort of not really entirely knowing what to think about this. Nancy, since I often turn to you when I don't know what to think about something complex on the national, is there any research on this? Is there any national data that sort of helps us understand what the impact of rising health care costs and job creation has been on other parts of the economy and the sort of opportunity costs to devoting so many resources to health care in terms of what it's doing to other potential areas of growth?

SPEAKER KANE: Obviously, I got a little warning about this question because I brought in an MedPAC study on this topic. Yes, there is some issue about where the jobs in our economy are these days. So MedPAC had done a analysis in their October '08 public presentation that basically showed over the periods 1999 through 2008, employment and health care grew five times faster than employment in any other sector of the economy.

And I think that when one realizes that

all of the other sectors of the economy are required to be able to pay for the sector that's growing, you can create some really cannibalization in a way. If you have to pay -- you have to have some people paying premiums in order to employ that many people.

You end up destroying jobs in the sector that produces the premium that pays for the job sector that's growing. It sounds a little complicated, but even the health care organizations when you read their financial statements, they often mention that their fastest growing cost is their health premiums and that they've had to raise their rates because their health premiums are going up.

So there's obviously pretty close interaction between the fact that health care employment is growing five times faster than any other segment of the economy. We recently updated our employment numbers in our March 2010 report to adjust what's happened in the last 24 months in the economy where overall employment has dropped over 5 percent over the last 24 months; whereas, health sector employment has gone up almost a little over 5 percent.

In other words, it seems to be a recession-proof source of jobs. On the other hand, the more that grows, the more you have to have the non-health sector pay for it. And the non-health sector is basically, I think the example by the fellow who owned the shoe store, was a great one.

His premiums went up by the same amount of money that he would have otherwise used to hire someone. We eventually get to a point where it's self-defeating. And it's not to say we shouldn't benefit from and foster growth in the health care sector, but I think it's a matter of balance and appreciate the need to keep premiums reflective of value and not some sort of goal of one sector, all employment should happen in the health care sector.

MODERATOR TURNBULL: So Tom, you're one of the people --

SPEAKER GLYNN: It's possible I might have used that phrase. Again, I don't necessarily think these things are incompatible. Just on the economic engine, you know, Brigham and the MGH are the No. 1 and 2 hospitals in the country with funding from NIH on a competitive basis pretty much year after year.

So in the last year because of the stimulus bill, we've gotten over $200 million of additional funds on top of 7 or $800 million we'd get every year from NIH. So that is I think an economic engine.

However, I think I tried to say, and Mary can probably say it more articulately tomorrow, we are for changing the system. Just because we're an economic engine doesn't mean we shouldn't change the system. We should change the system for all of the reasons that you articulated about, unsustainable levels of increases in cost which Stuart has talked about for many years.

The point I was making was if we're going to do something that effects one-sixth of the state's economy, let's make sure it's evidence based. Not let's not change it. Let's change it. But there's a lot of different kind of theories percolating abroad in the land.

I think it's important as this exercise

has been designed to do to get evidence and get data on the table so we can make an informed judgment as a community, which may or may not be what we would do. At least it's informed and data driven.

So I wasn't trying to argue for not changing. I'm for changing. I was just trying to say that we do it as a result of exercises like this where we can get to openly discuss it.

MODERATOR TURNBULL: So we're coming towards -- we're at the end of our time. So I just have one more question that I want to ask people. This is a question from someone in the audience.

So that there seems to be a lot of agreement, I think this is true, that something needs to be done in this area. And Tom quoted you, Tom said, We may be doing things, but not fast enough. And I think we hear a lot of urgency from the Governor, from the Senate President, from others, and I think from many of you and a lot of people on Tuesday to do something quickly and urgent.

So could each of you tell me, we'll just go down, what's the one thing that you think we could do in this area to get results quickly?

SPEAKER ANDERSON: Well, I think I can start by saying that I think that there is a real need to pay for value. And if we could do that in a meaningful way that that would make a significant difference for hospitals like ours and physicians in our area and our patients. And that also it would be one step forward in really being able to come up with a lower cost system that still provides high quality for health care reform.

SPEAKER DREYFUS: Significantly accelerate payment reform and align that with product and benefit structure.

MODERATOR TURNBULL: That was two things.

SPEAKER GAUNYA: As it relates to Mass. health care reform, undertake a very quick action to evaluate minimum credible coverage and reduce our standards for minimum credible coverage to allow employers to save money; and therefore, pass that savings onto their employees.

MODERATOR TURNBULL: We'll talk about that later, Mark.

SPEAKER GAUNYA: I figured you'd appreciate that.
SPEAKER GLYNN: 100 percent pay for performance led by the public sector.
MODERATOR TURNBULL: So 100 percent meaning what, Tom? All pay related to performance?
SPEAKER GLYNN: Yes.
MODERATOR TURNBULL: Knowing how quickly the public sector moves?
SPEAKER GLYNN: Okay. I didn't say dependent on.
SPEAKER LODGE: Develop limited network products immediately and put them in place.
MODERATOR TURNBULL: Okay. Julie.
SPEAKER PINKHAM: I think I'll just say globally relook at regulations.
MODERATOR TURNBULL: Relook at regulations. Okay. Nancy.
SPEAKER KANE: I guess we're in the same boat here. I would say reinstall public oversight over the entire pricing and payment system and potentially push that towards an all-payer system that's accountable and transparent to the public.

MODERATOR TURNBULL: I think we heard a range of things which are not mutually exclusive which I think goes to the point that Paul Ginsburg made that there are probably solutions which are both regulatory in both markets. So I want to thank you all very much for what I thought was a lively panel and turn it over to Commissioner Morales.

COMMISSIONER MORALES: Thank you so much. Before we conclude, I'd like to do two things. The first one is definitely thank the panelists, thank Nancy Turnbull. Thank you all for being here and staying through this, such an important discussion.

The second thing I want to do is just as a sit here I jot things down, notes, ask my team to jot important things down. I want to recap some of the things that really stood out for me as I did Tuesday afternoon.

The first is Stephen Schoenbaum from the Commonwealth Fund highlighted five key strategies for high performance health systems. While Massachusetts has extended affordable health insurance to all, we still have work to do in the five areas he outlined including aligning financial incentives to enhance value, ensuring care coordination and accessibility, improving quality, improving public/private collaborations and defining clear sets of reform measurement tools.

The delivery system panel agreed on several issues, fee-for-service payment structures, incentives inefficiencies in the delivery of care and contribute to higher costs. A number of the panelists pointed to examples where capitation or global payments have made a difference in the outcomes of care.

Although limited networks might work to support cost containment, they have historically been difficult to sell to employers and consumers and therefore need to be made more attractive if we should pursue those.

There was an agreement that the disclosure of cost and quality information can create the accountability that is needed to create a more efficient system, delivery structure; and the need to strengthen primary care in the Commonwealth was also an important theme.

Dr. Ginsburg echoed the need for change in provider payment methods, going beyond just focusing on price. And he reminded us that historically, utilization has been an important cost driver. Dr. Ginsburg cautioned that care should be taken with transparency, particularly on costs which can have unintended consequences and create a race to the top.

He suggested that transparency be combined with giving consumers a greater role and incentives to choose efficient providers. When asked about the best options for success, Dr. Ginsburg focused on three issues. Payment reform is the first step toward a more effective and efficient delivery systems. 2., explore consumers incentives and product changes, and 3., a combination of regulatory changes and market adjustments.

From the final panel, we heard arguments against the wide variations in prices paid for the same services delivered by equally qualified providers. It was also recognized that several other factors also contribute to cost such as the aging population and increases in technology, increase in utilization as well as rising prices.

The vast amount of information provided here today provided a strong foundation for our shared thinking about how we move forward and next steps for both policymakers and industry leaders.

What's clear to me is that the need for action is urgent. We need to do something now. We have to mitigate the health care costs we're seeing. We have to get to a different delivery system of care.

An even more in-depth dialogue about specific policy options will take place tomorrow where we will convene for our third and final day of hearings. I'll see you all tomorrow at 9:00 a.m. Thank you.

(Whereupon, the proceedings concluded at 4:35 p.m.)

C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS
ESSEX, SS.

I, Christine L. Warwick, a Notary Public and Certified Shorthand Reporter duly commissioned and qualified in and for the Commonwealth of Massachusetts, do hereby certify that the preceding transcript is a true and accurate transcription of my stenographic notes taken in the foregoing matter taken to the best of my skill and ability.

IN WITNESS WHEREOF, I have hereunto set my hand and Notarial Seal this ninth day of April, 2010.

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CHRISTINE L. WARWICK
Notary Public
Certified Shorthand Reporter

My Commission Expires:
May 14, 2010

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Massachusetts Health Care Cost Trends
Final Report

Appendix C.5e

Health Care Cost Trends Public Hearings

Transcript for Morning Session
Friday, March 19, 2010

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COMMONWEALTH OF MASSACHUSETTS
DIVISION OF HEALTH CARE FINANCE AND POLICY

ANNUAL PUBLIC HEARING UNDER
M.G.L. c.118G, SECTION 6 1/2
HEALTH CARE PROVIDER AND PAYER COSTS
AND COST TRENDS

PANEL:

David Morales, Commissioner, Department of Health Care Finance and Policy
Thomas O'Brien, Office of the Attorney General
Joseph Murphy, Commissioner, Division of Insurance

HELD AT:

University Club, 11th Floor
Joseph P. Healey Library
University of Massachusetts, Boston
100 Morrissey Boulevard
Boston, Massachusetts 02125
On Friday, March 19, 2010

Morning Session Commencing at 9:00 a.m.

COPLEY COURT REPORTING
The Mercantile Building
71 Commercial Street, Suite 700
Boston, Massachusetts 02109
(617) 423-5841

I N D E X

PROCEEDINGS

COMMISSIONER MORALES: Good morning. Thank you again for coming this morning as we begin the third and final day of the cost run hearings. First, I'd like to thank my partner in crime here, Assistant Attorney General Thomas O'Brien, who has been diligent and a great partner. I'll be joined soon by Commissioner Murphy, who has also been an extremely helpful partner in this. I want to outline where we've been in the last couple of days and talk a little bit about today's agenda.

As many of you know, Chapter 305 of the Acts of 2008 directed the Division to issue reports on health care costs and to then hold public hearings with key stakeholders of the health care system to help determine the best course of order with action-oriented solutions.

These hearings have a culmination of over a year's worth of researching health care cost growth in Massachusetts by the Division of Health Care Finance and Policy, the Office of the Attorney General, the Commissioner of Insurance and many other key stakeholders.

On Tuesday, we heard from experts about the specifics of health care cost growth. We heard alarming facts and need that remind us of the urgency of this problem. We heard from employers and consumers that are grappling with escalating health care costs.

Well, there's no question that Massachusetts leads the nation on access to health care. The rapid growth in health insurance costs cuts into peoples' wages, burdens families and hurts our economy.

On Thursday, we examined the factors that contribute to high health care costs in Massachusetts including the structure of the health care system and the payment methods currently used by Massachusetts health insurers.

We heard about an array of issues ranging from price variation, lack of coordination of care and disparities in the insurance market. We heard common themes from different constituencies, everyone from the leaders of our state's largest hospitals, to those who represent the consumer voice.

The problem with health care costs are

real. It's urgent and it needs to be addressed soon. It needs to be addressed promptly, but it needs to be addressed with a full understanding of all of the dynamics of our system including the characteristics and the issues that need to be fixed.

These hearings have attempted to generate a common understanding of the complex but pressing dilemma we find ourselves in as a Commonwealth. Understanding these factors will better prepare us to evaluate and develop reforms that have the potential to simultaneously contain cost growth and improve our quality.

Today with all of the urgency and information on the table, we turn to solutions. We will begin with a presentation of cost mitigation strategies by expert witness, Stuart Altman. Following his testimony, we will hear from a diverse panel to discuss their perspectives on such policy options.

The panelists will be sworn in, and will therefore provide their testimony under oath. While the moderator will ask the majority of questions, we at this Panel may intervene at any point.

Similar to the past few days, I'd like to encourage you all in attendance to engage with those providing testimony and with the information being shared. Members of my team will pass out index cards. Please, please, I encourage you, please write out your questions. We'll pass them to the moderators. As some of you know, we will engage you in a conversation.

In addition, there will be an opportunity for any of you to provide brief comments at 1:00 p.m. where we will open up the microphone for those in attendance who wish to share their testimony or comments. There's a sign-up sheet at the registration table, and I encourage you also to do that. Your insights will help inform the Division's development of the final report to the legislature.

Lastly, in addition to the agenda, the acts of the Attorney General led by Tom O'Brien will call Beth Israel Deaconess and Tufts Medical Center at the conclusion of our public comments. Tom O'Brien will ask a series of follow-up questions to that entity.

I don't know if, Tom, there's anything else you want to share at this point

MR. O'BRIEN: Thank you very much, Commissioner Morales. We appreciate the work that your team has put into these hearings. We have been pleased to participate in this process with you. We have obviously asked a lot of questions to the pre-filed testimony process to payers and providers.

We asked supplemental questions to both payers and providers to make sure that the record was complete. And while we've received that supplemental information from a majority of the entities, we still have outstanding information requests from both Tufts Medical Center and from Partners, the Partners System.

And until that information is supplemented into the public record, we're going to continue to reserve our rights with regard to these hearings. We do anticipate that that information, based upon our discussions, will be submitted in the very near term; hopefully Tufts Medical Center by the close of business today; and with regards to Partners, the additional information on advertising and marketing that has been omitted to date will also be submitted in the near term.

COMMISSIONER MORALES: Great. Thank you. Just as a point of information, every, each and every piece of information that we have submitted to the Division of Health Care Finance and Policy we will and have placed on our website. So if you're interested, there's plenty of information for you to read there. Whatever else is outstanding obviously within bounds will be placed on our website as well.

Last point is we will try to end promptly today before five, true and to the form we've kept in the last couple of days. Without further ado, Professor Stuart Altman, you're on. Thank you.

MODERATOR WEIL: I've got to get sworn in again, right? Good morning. I think those are the only two words I'm authorized to say before we're sworn in.

(Speakers sworn.)

MODERATOR WEIL: Good morning. My name is Alan Weil. I'm the Executive Director for the

National Academy for State Health Policy. We're an independent nonprofit organization dedicated to improving state health problems.

While I have no conflicts, I do want to note three connections I have to the Commonwealth. The first is that I lived here for eight years, and my first job after graduate school was that the then Department of Medical Security which no longer exists.

The second is that I was the co-principal investigator in the Blue Cross Foundation Program's coverage which led into the enactment of health reform. Third, and probably most important, my middle daughter, Sophia, was born on April 12, 2006, the day Chapter 58 was signed into law.

With that, I want to turn over the podium to Stuart Altman, known to all of you, of course, as the Professor of National Health Policy, a tremendous national and state level expertise to begin the discussion today about solutions. Dr. Altman.

SPEAKER ALTMAN: Thank you. Thank you, Alan. Well, I've had the opportunity to and privilege to testify more than a few times in my career, but I find it much easier to do it when I'm in Washington or in other areas because I can tell them all the crazy things to do, and then I know I can come back to Boston and get good health care and not worry about all these other things I told them to do.

But here I am in Boston telling people who control my life what to do. So it's a little bit daunting. And to make matters worse, normally, I'm pretty open-ended about making presentations. But with all the lawyers in the room, if I was ever going to get nervous, this is it. I'm most concerned about Delores sitting in the front row because indirectly she provides the insurance that wraps around my Medicare program, so. With that said, I would be tongue-tied. But I'm going to keep going anyway.

I do want to make clear that as I said yesterday for those of you who were here, actually, I have a lot of conflicts of interest. I have so many that I'm purely objective. First of all, I'm very proud to be on the Tufts Medical Center board. I used to be on the Beth Israel board. A lot of my friends are on Partners.

I'm very sympathetic to the community hospitals here in Massachusetts. I also sit on a number of insurance boards, none of which are located here in Massachusetts. My career goes all the way back to the early seventies.

I was the first regulator for the United States, and I know the benefits of regulation. And I also know the problems of regulation. Stan Wallack and I were both 6'2", 6'4" at the time. Both of us now have been cut down to size. For those of you who have aspirations of being the next regulator, I warn you. I want to make it very clear, I'm falling apart. I care a lot more about the health care system than I did when I was 32 years old.

So with that said -- the other thing I want to say, I do spend a lot of my career going around the country and talking about health care. And quite frankly, I'm very proud to be a citizen of the Commonwealth. I think we have an incredible health care system; second to none in this country, if not in the world, both the quality of our hospitals, our health plans, our doctors, you know. I don't care which measure we use in terms of quality. While nothing is perfect, we do have quite a good system.

The second thing I want to say is that -- somehow this got out of line. While it is true that the quality is great and it's also true that it spins off a lot of benefits to our society, I mean, I live along 128 as many of you do.

And many of the software and tech, biotech companies that are in Cambridge and along 128 really move out from our universities and our health systems. So it's fair to say that Massachusetts is a medical mecca. And we should be proud of it, and we should protect it.

Nevertheless, I think we've heard over and over again, and I share, we need to be very mindful that there is a problem. And it is a serious problem. And that is that the cost to keep that engine going and moving generates a lot of downside negatives.

It generates negatives in terms of individuals and employers and their ability to support the system, and it generates negatives in the loss of jobs outside of the health care system.

So we have the benefit of a lot of jobs and high-paying jobs and high-quality jobs in the health system, but we also extract, as we talked about yesterday, a lot of the money that could have gone for more jobs outside.

So we have a problem, and we also need to be very mindful that in trying to solve that problem, we don't kill literally the baby with the bath water. So if you find my presentation is in the right direction but maybe not as aggressive, it comes from what I think is balanced trying to deal with it.

Now, there's been a lot of talk about the costs and the price of health care, and we got to squeeze down on the prices. We've got to do this. We've got to get this, this is a great curve, and I really want to thank the Attorney General's Office and all of you who did all the work on this. This will live with us for years in terms of explaining.

On the other hand, you can spend too much time on it. Because in my view for what it's worth, what we really need to work on is not the current prices that different groups are getting or not getting, but restructuring the delivery system so that we can maintain the quality of care we get, if not improve it while over time we lower care. That's where I'm coming from.

Now, so on the delivery system restructuring that, I mean, that's where I come from. But I also know that we will never, ever really redesign the delivery system unless we put in the proper set of financial incentives. You heard yesterday, and I see it all over the country, trust me, I spend -- some of you know me well. When you ask people where I live, I live in 14A on some airplane because I'm around the country; and my life ambition is to be in 2B.

And I hear this over and over again from well-meaning hospital administrators, physicians and so on which say I want to do X, but it's financially disadvantaged for me to do it; that basically, if I keep people out of the hospital, if I could do the right thing, I financially lose by doing that.

And while I try -- and we mentioned Geisinger in Pennsylvania and Virginia Mason in Seattle, the Mayo Clinic and Cleveland Clinic, and many of our hospitals here and teaching hospitals here in the Boston area as well.

So we need to change the payment system. You've heard that over and over again, and I can't emphasize it more. If we don't change the payment system and we try to clamp down on prices, which is what I tried to do in the early 1970's -- first of all, it's impossible.

Ultimately, the system will overrun you. That's strong advice. You cannot regulate this industry unless you change it. You need the industry to be on your side. And the only way it will be on your side is if we make the incentives working in the same direction that you want.

So the question at the heart of it, which is what we talked about over the last couple of days, is how do we get from here, fee-for-service and fragmented care, to where we want to go, which is bundled payments and ultimately integrated care?

Now, many of you have heard and written

and read about accountable health plans. And I didn't create the term, but I think it's a good term. And really, then the next question is, Well, if you're so smart, what is it? And of course, it's a lot of things. Basically at its heart, it's an organizational structure where the organization takes responsibility for all the care of their patients.

They don't necessarily have to provide all the care. You can have an accountable plan, accountable care plan that is a truly integrated system that everything comes out of the same central command. Or you can have one which is a virtual one where groups come together in a kind of like -- they don't get married, they live together. It's kind of like they work together.

So how do we get from this fragmented fee-for-service to this integrated care, and as I said, bundled payments? Now, this is a tough issue. I was trained in a very conservative economics department where the market was king. Well, I would have never have gotten my Ph.D. if I didn't believe in it. But then again, I was 26 years old, and I wanted to get out.

The truth is that the markets have a lot of influence. When markets work well, they work very well. And they are by far our best. I do not believe that given the configuration of our health care system in this current environment we can rely on the market alone to restructure the payment system to get the delivery system to move forward.

I want to commend Blue Cross. Blue Cross was the first made -- Blue Cross of Massachusetts was the first major payer in the United States, not just here in Massachusetts, to move forward on a new form of a payment system. They're accountable, their new form of payment on a bundled payment. But alone, it can't do it. It's voluntary. It does not have Medicare and Medicaid under it. It's just, it's not strong enough.

That doesn't mean that it's not working. We heard yesterday from Andrew that there were some very good things flowing out of it. But I believe at its heart, we need a more encompassing system. Some people call it all payer. Some people call it other things.

A statewide entity -- and by the way, my testimony, I didn't call it anything. It could be commission. It could be a cabal. It could be -- you decide what word you want to use. But the important thing, it has the power of government, state government to help restructure the payment system; and in so doing, restructure the delivery system.

Now, some people are sort of thinking ahead. Okay, we're going to do that. How should it be organized? Where should it be? The truth is that if you look around the world or look around the country, you could either be a part of state government; or in many cases, states and the federal government have set up quasi units that have governmental authority, governmental oversight but are independent.

Yesterday we talked at some length about MedPAC and ProPAC which I chaired which is an independent entity of this federal government established by an oversight of the federal government, but independent. It brings in experts like Nancy and little people like me to help advise it. And it has a separate staff, and it functions very well.

Also, the state of Maryland, which is the only state that still has some form of rate regulation, has a separate entity, separate commission that operates independently. The state has the authority if it chooses to go in and do something, but the ability of the state during the operating charter has limited impact.

So you could go either way. That's secondary to the more important thing is the willingness of the state government to do something.

Now, here is I know a controversial area. We look at this chart, and we've heard testimony that says that when we look at the differential payment rates, you can't really explain them based on any easily definable index of quality or the complexity of the patients.

And I know, I mean, I sit on the Tufts board, and we believe that we provide the best quality care of any institution. And we should be on the top of the list. Alan, you're listening. This is a commercial.

And we're not. So there's a tendency to

want to change that right away. And I was there too. But in my view, we should keep our eye on the long-term. And that is trying to change in the short run in some, I guess, draconian way, twisting this thing. It sounds good; but in my mind, it would be a mistake.

So I in thinking about what I'm suggesting, I would say, okay, let's start from where we are; but let's put the incentives in that move us in the right direction and do it in a way that over time rewards those institutions that provide better quality and other services that we as a community want so that over time if we get my system, if it worked right, you would see a very different chart in maybe five to ten years.

Unless the people on the top actually show that not only are they on the top because they're on the top, but because they actually are providing better quality care and more services that we want. By the way, somebody brought up in a question yesterday that I want to repeat, what are we talking about? Are we talking about paying hospitals or institutions just for the care? What about teaching? What about research? And I think those are very important issues.

I think as a -- no, I know as a community we need to be mindful that we have certain institutions to take on a greater burden, whether they run a burn center, whether they're more likely to have a high-end ICU or they're more likely to have a trauma center.

We need to take that into account when we develop these rates. Once you put the rates in, you can't let just simple brute force win. It has to be based on some internal logic and consistency. With that, so that's where I start. I know some of you will have a different point of view.

Now, this isn't going to happen overnight. When I served on the Medicare Commission back in the nineties to redo it, you know, the analogy was made many times that we're talking about an aircraft carrier or a big battleship. You just can't expect it to turn around overnight. Our health care system, 2.5 trillion dollars in the country and whatever the trillion, billion dollars in this hearing was developed over a long period of time.

So you're not just going to press a button, and it's going to immediately move in a different direction. So we've got to give it time. My suggestion is this new entity be given a five-year limit for the first go-around. Then again, the state government gives it to this entity. The state government retains the right to ask it questions, but I would suggest to the people who represent the state that they leave it alone; and they don't try to sort of micromanage it as it moves forward.

Now, as I said, I was a regulator. And in the beginning, it was a very heady experience; but the longer you're in the regulation business, and I've spent a lot of time in Maryland. For six years, I was an advisor to them. It gets very complicated, and it gets very hard to do.

So my preference is that if we get the system restructured and it's in the right direction, we can back off the regulatory stuff except for some key issues. As you can see in the proposal that I'm going to put forth, the state needs to establish some form of budget targets for each of the units that we're talking about. And it needs to evaluate the performance of the units relative to the budget. That can never stop.

So you can do that without trying to jerry-rig every little piece of the action. Ideally what you want is to set in motion the right set of incentives so our smart people that are running our big institutions and running these new ACO's have the same set of incentives that we want.

By the way, I want to deviate for one minute. For those of you who read about these kind of things, there's talk about well there's primary care that should be dominating and so on. You know what, we need a better primary care delivery system. But we have to recognize where we're standing.

We have in this state, in this Commonwealth a lot of very good institutions that are big teaching institutions. And they are dominated often by specialists and stuff like that. They can work provided they also have a good primary care. So the idea of whether it was primary care dominated or big institution dominated is less important than they all have the same set of standards.

So let me just briefly go through the system, and then we can talk about more questions. Basically, as I said, every payer needs to be in the game, including Medicare and Medicaid. We should not try to do this alone.

One of the things we need to do is have the state get a waiver from the government to allow us to function. Basically, the idea, and I want to give credit to Stan Wallack who's here, of Chris Thompkin, basically it's let's start from where we are and allow institutions to fall into one of three tiers.

Tier 1 would be fully integrated ACO's. These are institutions that are willing today or in a very short period of time to take full responsibility for the care of all their patients. And they will have either directly under them or contracting with primary care physicians, specialists, hospitals, secondary hospitals, tertiary, so on and so forth.

They will get bundled payments for all

the care either on an annual basis or at least for a certain set of diseases. And then over time, if they beat that, and there will be a target over time, if they beat the target, they get to keep the difference. If they don't, they get to lose. And in addition, there would be these quality standards and so on.

So they're in Tier 1. Tier 2 would be what I call virtual integrated ACO's. These are institutions that don't have complete control over the delivery system but come together so that you could have a teaching hospital. Then you have the primary care. You have specialists. They operate separately, and they each get fee-for-service payments. But there is a central command that works with them to work together.

So each of them gets fee-for-service, but the tier, itself, or the group, itself, gets a bundle. And again, if they beat the target, they get to keep it. If they don't beat the target, they don't. And we said, okay, that's Tier 2.

There is a Tier 3. There is a group of providers that whether either they're philosophically or emotionally so tied into fee-for-service that they just don't know what to do, they're going to continue to function under fee-for-service. Let them. However, that group in total will be under the same budget target. So if collectively they go off and have 47 MRI's for a bent toe, they're going to pay the price. But you don't force them into two or three. Let them evolve into two or three.

So again, quality standards are very important. We have to prevent skimping. Payments have to be adjusted for the health status of enrollees because you wind up with very different. There will be expenditure targets. There will be, as I said, Tier 3 will start from the thing. The hope is that over time we will see a transition from 3 to 2 to 1 as more delivery systems become comfortable.

Again, let me end by where I started. We have a very good, high-quality delivery system here in Massachusetts. We want to keep it. But we also realize that over time we need to slow or bend the cost curve because the impact on the rest of our system just is overpowering. So with that. I will stop. Thank you very much

MODERATOR WEIL: Thank you, Stuart, for laying out that vision and concrete set of steps to take in the shorter run. Let's start at the long-term vision point and then try to bring ourselves back to what it takes to get there.

I want to ask, you raise the role of financial incentives. I want to ask whether there's a difference between what you described as a financial system that supports those who operate in this integrated way and a financial system that pushes people and systems toward that kind of integration if they don't have that desire or leadership already today?

In other words, is it the same set of incentives that sustains systems that are doing what we want to do as moved systems to the place that we want them to be?

SPEAKER ALTMAN: Well, I think I understand your question, but I may not. Your question is, Is there an interim step between fee-for-service and bundled payments that moves us in that direction?

MODERATOR WEIL: Or will bundled payments alone which would clearly support systems that are operating the way you want them to also be the appropriate motivation to move others into that?

SPEAKER ALTMAN: Yesterday Paul Ginsburg and I think several of the panelists raised this, and I think they were right. If you just bundled payments but allow the bundles to be as big as the current bundles are, I don't think you're going to get there so fast.

Bundled payments are not a panacea. They're not by themselves all you need to do. They're a necessary but not a sufficient condition. I think you need both bundled payments expenditure targets. You need the bundles to be constrained over time.

So if we had to take, you know, one step at a time, you know, some people would have the budget targets first. I think the bundles should come first. But ideally what you want is both, the bundled payments and the expenditures.

As I said, if the bundles are so big that you can bundle in everything that you're now doing or everything that you conceivably think you're doing, it would have some positive incentive. But it really would limit the constraints in terms of the spending.

MODERATOR WEIL: Presumably, those targets need to apply to the rest of the system as well so that those, so that as organizations move into operating in the more integrated way that you suggest they are, they gain something by doing so?

SPEAKER ALTMAN: Yeah, right now, I don't mean to speak for the medical community, but right now what they do is they face a whole different set of spigots in terms of money coming in, different ways and different forms. And their job, I mean, that's why they're so good or so well paid or whatever, and that is to try to figure out how to maximize each of the spigots. And they're all different.

Medicare in some sense is the biggest problem. I mean, it's a fee-for-service system. It doesn't have any constraints on volume. It has constraints on prices, but not volume. It sets all set of incentives in one direction, and then you have different payers and different forms.

So you've got to get Medicare into the

game. Yesterday the discussion was also on Medicaid. Medicaid is a big player for certain providers. Now, we can fight about what the right rate is. By the way, when I make -- and I didn't make this clear. Each payer is not going to pay the same amount of money even though everyone should be in the system.

You're not going to get Medicaid to pay the same rates as the private. You could make a case that Medicaid ought to pay, you know, maybe more than it is; although, I think Nancy had a good comment yesterday. Medicaid is a state-run program and stuff like that.

The delivery system has a responsibility for making up some of the difference. Whether how much is an issue. So every one of the payers needs to be in the game in terms of providing the same set of incentives, but they don't have to start at the same amount.

MODERATOR ALTMAN: It's fairly easy to visualize that in a Commonwealth Care organization that's integrated, we have models of them around the country, but I think part of the language of the future is this notion of a virtual ACO or something like that.

It rolls off the tongue nicely, but it's a little harder to think about what it looks like. Can you either point us to one or tell us what the elements are so that we would know it when we saw it?

SPEAKER ALTMAN: Well, I think you've asked the right question, and I wish I had a good answer for it. You're absolutely right. It's easy to say and hard to do. It's hard to do on a number of levels. I can conceptualize what it looks like. Let's face it, there are very few totally integrated delivery systems in the United States. We talk about Kieser in California. Then you have pieces in Intermountain or Mayo. Partners is very close.

I mean, you know, it has a lot of pieces. Whether it has all of them, they're all tied together in the right way, and Tufts has a lot of the pieces too as does the Beth Israel Deaconess.

So you know, they're close. They could be Tier 1 if they choose. But most of the delivery systems in Massachusetts, the community hospital, the physician groups, the primary care groups, the specialists still are functioning as units.

So what you need as -- but at the same time, they want to work together. You would need a group in the middle, whether it could be one of the pieces that takes on that responsibility or a new piece that is formed that sort of takes responsibility.

It goes back to the IPA models in the 1970's and 1980's where you had a, it's like a central command that takes the money and then deviates. To sort of prevent some of the problems, if you gave into this one unit, then they would have to divi it out.

What we try to do here is allow each of the units that continue to be paid a fee-for-service what they're now getting but recognizing that their ultimate financial gain rests with the ability of each of the units to do the right thing. And that's what this is.

MR. O'BRIEN: Just to put it in a different way, for Tier 1, is that by definition a form of managed care product, like a health maintenance organization product? Or could you function with that integration in the PPO structure?

SPEAKER ALTMAN: Well, I think the PPO structure would more be 2, but that's on the payer side. This is on the delivery side. But I think your analogy is a good one. The fully integrated HMO that we envisioned back in the early seventies, the Kaiser model is the closest thing to a fully Tier 1 system, where all the pieces are under one roof or under one central authority.

And the PPO model, which is someplace between 2 and 3, is a much more loosely affiliated group of providers where in that case the plan maintains the central command. What we're talking about is the delivery system, but it's a good analogy.

MR. O'BRIEN: If I could just follow up. Part of it is two things, first off, thank you for not only your comments today but the work on this progress and the work that's being done by the Commonwealth. You mentioned budget targets. Is that a form of reference pricing, or is it budgeted off the existing financial structures?

SPEAKER ALTMAN: Well, we're going to start as I said, I mean, my preference, and you can differ about this, would be to allow each of the units to start from where they are. But to say, let's say, that left alone we assume that medical inflation is going to go up by 6 percent, I think the state needs to be very careful. You can't make up numbers.

One of the things I didn't say but I want to say very strongly is we have to be realistic at two levels. First of all, we have to realize that most of the pressures on our institutions are not generated internally. They're the federal pressures; how much I have to pay for drugs; how much I have to pay for technology; how the health care system has changed.

But with that said, there's no reason why we can't set inflation targets that are a couple of percentage points. And that's an interesting discussion, how low we make those budget targets relative to where we think the system would have gone if we did nothing.

MR. O'BRIEN: Just one last follow-up.

At least I think it's only one, sorry. If you have these fully integrated Tier 1 structures.

SPEAKER ALTMAN: Yes.

MR. O'BRIEN: Under the current market, I don't know if there's any dispute that there's a significant amount of subsidization taking place. If you get care in less expensive locations and the risk pooling of insurance, the cost of actual delivery systems is blind to you. There's no incentive to pick one over the other.

Obviously, the GIC and others are making strides toward that end. What is the economic argument for having subsidization across Tier 1 level accountable care organizations? Stated another way, wouldn't you drive volume to more expensive ACO's if you said here's a less expensive ACO on a total medical expenditure basis, but that you won't pay anything more to go to the more expensive ACO without financial incentives posed to consumers as well as institutions?

SPEAKER ALTMAN: I understand where you're going. Let me give maybe not the greatest analogy, and forgive me if I offend anybody by saying that. Let's say we're two people, and one of them is a little heavy, and one of them is a jogger and watches what they eat and does all the right things. Then you say everybody has to lose five pounds.

Well, you say the person who's heavier and stuff like that, it's easier for them to lose it because they have extra stuff to begin with. The reality is the people who are well disciplined often do a better job than the ones that aren't.

If you have a delivery system that's sitting up on the top that, with all due respect, does not have the discipline to keep their costs under control as opposed to the ones that have been living under a tighter budget and then you impose a budget on both of them and the budget is the same, even though they started out like this, I'm betting that this team knows how to play and over time will do a better job, because they're both facing the same.

This team is not going to just be able to make up numbers some would say the way they do now. They're going to have to live under their target. So over time, by and few, these things are going to begin to look like this. Besides -- that's the way I hope.

Besides, trying to get at this, first of all, if you do it fair and you start coming up with a complexity of how you pay this thing, including all these things like teaching and research and stuff like that, it may turn out that the gap is not as nearly different as you think.

There are some that look like that. I understand the argument. Some would say let's take the fat away from here, start like this and then go forward. My preference is to get going.

MR. O'BRIEN: Just again, just as a follow-up, it's not suggesting that there's fat in any part of the system. That's not the approach that we took as far as our analysis. It's more a question of whether the incentives to both employers and consumers, wouldn't everybody rather be in 2B than in 14A? If you're driving volume by equalizing the price of it being in front of the plane and the back of the plane, isn't there --

SPEAKER ALTMAN: Wait a minute. What we

heard yesterday and what we know is that some of them that are not up at the top are providing good quality care, more caring care. You know, what we found and what you found, in fact, you ask that 14B looks like 2B. In a lot of variables as a patient, a lot of patients are going to these other institutions, whether it was Winchester or Lawrence or Tufts even though they're not up on the top.

So I don't anticipate going forward -- one of the things we did here is that if we continue to pay the top ones the top, not only do they have more money to continue to do it, but they also have a way of getting more of the physicians and they're gradually taking a greater percentage of the whole state with them.

Over time, they're not going to be able to do that. I understand why there's a feeling to go down quickly. Believe me, if you could figure out a way to do it, I'm not arguing that that doesn't have some merit. But if you keep your eye on the long-term, I wouldn't personally fight that battle. But it's going to be a call that someone has to make.

MODERATOR WEIL: I want to bring us as close as we can to the steps to take -- let me ask based on your experience with ProPAC, your reference to Maryland, very hospital-centric rate setting systems. The data, the chart that you kept saying was going to last for years is hospital-centric.

We also have, of course, lots of other actors in the system. How much of this attention authority should be focused at the hospital level?

SPEAKER ALTMAN: Well, I think you raised a very good point, Alan. First of all, I would not duplicate or replicate the Maryland system for just the reason you gave. It's very hospital-centric. It focuses on inpatient care. It doesn't do a very good job at focusing on outpatient care.

I would tell you this. If Maryland laid out its slides, it would look just like this one. Trust me, my friends, and they are my friends at Hopkins, they do okay, thank you. You should hear this community and the rural hospitals in Maryland complain about all the money that's going to Hopkins.

Just because you have a regulatory system, don't think you're going to do away with this, nor should you. I mean Maryland is a very proud populace. So A., two things. First of all, I wouldn't do a hospital-centric because of what we learned. And that is so much of an accountable care needs to be out of the hospital. It needs to be.

Just because I said in many cases the integrated delivery system is going to be in the central command of a big teaching hospital and given the fact that that's what we are, we're not going to wait. We're not cancers. So we're not going to wake up and say, all right, you know, we're just going to do away with the top 4 or 5 teaching hospitals and stick it in some primary care place or whatever.

But where that's said, if those top heavy institutions with a lot of specialists don't focus their efforts on primary care, they're never going to hit those budget numbers. By the way, our big teaching institutions, they do have a lot of primary care doctors.

It's just a question how they want to use them and whether they want to keep people in the hospital or out of the hospital. I would not do Maryland. You need to change the incentives so it's in their best interests. Don't try to run it from central command.

It's in their best interests to keep people out of the hospital, to link up with the community hospitals where they can and to use the specialists in the tertiary care only when they need to.

MODERATOR WEIL: When you introduced your three tiers, you talked about the first tier, you used the word institutions where you taking responsibility. Are those provider institutions? Are they insurer institutions? If they're provider institutions, where does the insurer fit in this?

SPEAKER ALTMAN: They're primarily providers. And insurers continue to do what they do which is they continue to sell policies. What I didn't talk about, and there was a lot of discussion yesterday, is we need to decide two things. I apologize.

One is how you design the insurance packages. One of the things that we danced around yesterday is the role of the patient. And all we did was to say, oh, the patient is wonderful. We got to get the patient into the game. But there's another side of the patient.

And for those of you who are patient advocates, patients have to be in the game not necessarily the way they are today. You know, one of the issues that the delivery system people face is patients bopping in and out of the delivery system.

If the delivery system has responsibility for budget, but the patients can flip from delivery system A to delivery system B, want all the care, you know, want all the -- patients need to have the same set of incentives as the insurers and the delivery system. They need to be concerned about where they go to. And I think that was what Tom was getting at.

So the insurers have a role, but the one role that they, that we're taking away from them because, for two reasons, they can't do it because they're not strong enough. And we don't trust them enough because when they did have the strength under managed care, we beat them up.

And we said, we don't want insurance companies deciding what our delivery system is like. Now we look at our state. As Nancy pointed out, we got one insurer, 50 percent of the patients. They admitted that they don't have the power to always dictate what the rates are.

I think that needs to be a safe responsibility. With that said, the insurers can play the game. They can do a lot of things. They can help these things along. They can facilitate things. There's a lot for the insurers to do

MODERATOR WEIL: Then can a provider play in multiple tiers? Or can you --

SPEAKER ALTMAN: That's a good question. Theoretically, I think we envisioned or at least I envisioned that providers would be in one of the tiers. They wouldn't be in all three tiers at the same time.

That's another thing that broke apart which is when you look at the idea of managed care, a provider would be doing A rather than B.

But then everybody would want every doctor and every unit, and the whole thing would break apart. So providers should be in one.

FROM THE FLOOR: I'll modify that later, but that's basically true.

MODERATOR WEIL: You envisioned growth targets in each tier. Are those growth targets the same by tier, or do we need to put a stronger clamp on Tier 3 because of greater risk of cost growth?

SPEAKER ALTMAN: No, I think they should be the same. I think Tier 3 is going to have a hard time because basically no one's in control. They have to have the incentive to do more. And then all of the sudden at the end of the year they're going to wind up, they're spending -- their growth is 8 percent, and the target is 5.

Then all of the sudden there's going to be a lot of money taken back from them because they don't have any, they don't have any discipline. So I would have the same targets on all of them.

MODERATOR WEIL: And given that this is sort of the short-term or middle-term agenda, some of the factors that you envision, accountability, risk adjustment, can we do these quickly enough to integrate them into a short-term strategy? I know there's a long-term agenda around those. If we're going to adopt short-term policies that rely on these kind of techniques, are they ready for prime time?

SPEAKER ALTMAN: Well, as you know, well, Alan, we have spent the last 30 years in the research community trying to create risk adjusters, trying to better understand how to do things. Are we there? Are we perfect? No.

I mean, we come up with risk adjusters where the problem, you know, the correlation is .3 which is that it's not great. But we are far better prepared today than we were in 1971 when the president and me were running around the country saying every hospital can only raise their prices by 2 percent; and like everyone said, but, but, but, we have sicker patients.

And we have no way of knowing. Now we have a DOG system. We're much better today, but we're not perfect.

MODERATOR WEIL: I know we're better.

But I guess the question is, If you went to the provider community, the payer community and said this is as good as we have, and we're now instead of having this graph where we can't explain it, we are going to basically force it into explaining it by the factors that we do have, are we ready to stand up to the provider system and the public and say this is the right way to do payment?

SPEAKER ALTMAN: The reason why I created -- no I created -- our team created what is fairly conservative in terms of changing the system is because we don't know everything. So this gives the providers a lot of choice. They can basically go in one of the three tiers.

It does not restructure the thing, the payment because it may turn out that even your measures, as good a job as you did, those indices are far from perfect.

So we, this is deliberately designed to recognize that we have limits in terms of our knowledge base. And so I would hope that most providers would look at this and say, hey, this is a reasonable shot. I've got a shot to play. And it's not forcing me to do things either I can't do or are unfair. And yet, I think it moves us in the right direction.

MODERATOR WEIL: So Tier 3, your level really is price at the end of the day because you have no volume control in Tier 3 because there's no organizer? So you basically say for cost containment if they're 3, our lever is price. Your hope in Tier 1 your lever is delivery system improvement which is our long-term goal. In the middle, is it both of those? Is it neither of those?

SPEAKER ALTMAN: Well, I hope it's both. In the sense that it still has central command. So there is still, the central authority in that group has responsibility for making sure that volume doesn't get out of control, that they're not doing things that don't make sense. It also has some idea of allocating patients.

The group has to get together. It's a group-think here, but I think your analysis is absolutely right. The third tier is still the wild west of today. But over time, they're going to realize being in that environment is financially painful. And the hope is that they will figure out a way to move into 2, and then some of the 2's will move into 1.

MODERATOR WEIL: Presumably the reason we would not take the Medicare experience as cause for discouragement is because they're politically with the sustainable growth rate, you can go back and renegotiate price after the fact. But we're going to be tough here and say, you just have to live with your 3 percent rate cut because your utilization went up by 8.

SPEAKER ALTMAN: Well, you and I know, most people here know what the sustainable growth rate is which is -- with all due respect to the people that created it, it was the wrong rate. It was designed wrong. It wasn't wrong in concept, but it was too tight.

Two things I would say in conclusion. The reason why HMO's failed in the nineties to be the panacea that we hoped is they got too tough, that they accepted the low end of the actuarial curve too quickly. And as a result, the delivery system couldn't deal with it, and then it boomeranged against them.

The same thing with the sustainable

growth rate. If you create a budget target that is unsustainable, the system will fight you to the end. And ultimately, we will fail. So you can't wake up in the morning and say, oh, I think the growth rate ought to be .5 when the rest of the country is going up by 6.

It just will create the wrong set of -- that sustainable budget needs to be realistically set. Yes, lower. Yes, bending the curve. But not so low that the system can't function.

MODERATOR WEIL: So I would just close with a question of, In your assessment of the ability to bring the whole system under this structure that you've described, we've got ERISA plans. We've got Medicare and Medicaid. Admittedly, again, we're talking not levels but rates of change, do you see the plan you've laid out as amenable and acceptable to those payers?

SPEAKER ALTMAN: I've been around a long time, and I can guarantee that it won't be. I mean, everyone's going to figure out a way, well, it's not part -- but we've got to get, I don't know what percentage, 70 percent. We don't need to get 100 percent of the payers into the system.

But we need to get enough of them into the system that the delivery system people see that the majority of their money is coming from a force as opposed to the current environment where they're always trying to maximize everything.

So you know, as I said, I've been around a long time. Any solution that has an aggregated figure attached to it will be fought by some groups. I'm hopeful that Medicare, which is a real part of the problem, will be more flexible going forward and is willing to participate. If Medicare isn't willing to participate, we've got a -- it's hard for us to do this alone.

MODERATOR WEIL: Thank you, Dr. Altman. Thank you for a terrific presentation.

COMMISSIONER MORALES: Thank you also to Alan Weil for his great job moderating. We're going to take a short two-minute break to organize our panel. We'll come back promptly.

(Short recess taken.)

COMMISSIONER MORALES: Good morning everyone and welcome back. I want to begin the morning by first acknowledging Attorney General Martha Coakley who is here with us today.

ATTY. GENERAL COAKLEY: Good morning.

COMMISSIONER MORALES: Without further ado, I want to now introduce our now distinguished panel. First, Alan Weil will now take over.

MODERATOR WEIL: Thank you, Commissioner Morales. Again, we begin with --

(Speakers sworn.)

(Ellen Zane raised hand after swearing and follow-up questions.)

MODERATOR WEIL: Good morning. Before we turn to the panel, I just want to note how critical these hearings are. As we as a nation move towards a key vote on comprehensive health reform at the national level, it is obvious that we're going to have to, as you've done in Massachusetts, shortly thereafter turn to a discussion about cost, the cost drivers, what can be done to improve the delivery system.

Just as the Commonwealth of Massachusetts has led the way in coverage, I think these hearings are a sign of leadership also on the topic of cost. And in that vein of breaking new ground, they're also challenging and difficult but necessary. So a look forward to the presentations and the discussion today.

To preserve the time for content, we're dispensing with long introductions. I'm just going to ask the witnesses to go in the order you're seated, to keep an eye on the timekeeper. If you don't, I will. And I'd rather not.

Without any additional delay, as you introduce yourself, please state your name and organization. Ralph de la Torre.

SPEAKER DE LA TORRE: Thank you. Ralph de la Torre. I'm the president and CEO of Caritas Christi. Commissioner and Attorney General, thank you for inviting me and this panel to share some thoughts with you. I think we're at a critical time in society when it comes to health care reform. We all acknowledge currently, especially in Massachusetts, that there's two components of health care reform that need to be addressed, access and cost.

I'll talk about quality in a second. I think that we as a state addressed access fairly well. I think that we acknowledged at that moment that we really didn't have a good solution for cost, but we felt there was a morale imperative, a social justice imperative to make sure people all received adequate health care.

For that, I think we all as a panel take a hand in applauding the state. Quality, quality is a paramount concern, and to strive for it is something that permeates every one of our organizations. It is probably, most would agree, not the fundamental problem in Massachusetts. It's not necessarily what's broken which leads us to the cost component, one of the reasons we're here.

One of fundamental equations that I believe help govern health care is that the cost is equal to a product, a product of a function of access and a function of quality. In other words, if you increase access without changing the underlying methodology by which health care is delivered, it will lead to an increase in cost. It is virtually a linear relationship.

The quality relationship is a much more complicated function for a different discussion. So when we look at and we say we need to address the costs while maintaining the access and the quality, how do we change the underlying methodology by which we provide health care?

I think many of us have come to agree that the fee-for-service system is broken. It incentivizes the wrong kind of care. I always kid around that if we invented a cure for heart disease, there would be two huge pluses, and one huge plus and one huge minus. The huge plus is people would live longer and live healthier. The huge minus is it would bankrupt most of our institutions overnight.

Too much care is delivered to Massachusetts in expensive settings. No one argues that the tertiary, important care structure that exists in Massachusetts is phenomenal and for high-end care needs to exist. That's not the problem.

The problem is that too much basic care travels long distances to provide a higher and a more expensive setting. Also, care needs to be preventative. We need to be treating instead of trying to prevent it. Also, we need to get employers and employees united in the way that health care is paid for so that there is a fundamental understanding.

And that might lead to the way that premiums are covered. That might lead to the way that networks are chosen. We at Caritas Christi fundamentally believe in an accountable care organization. Many of you do not know it; but in the last two years, we've led a massive internal reorganization to provide just that.

Our 1,200 physicians are fully integrated and at risk together with the hospitals. We have created our hospitals' share bottom lines. We're all one entity. We have created an IT platform that by the end of this year will have every, single physician in our network on, being computerized as well as every hospital.

We'll have DHR and EMR in all of our institutions. We partnered with all institutions and all 1,200 physicians together. We partnered with 1199 SIU to create a robust training mechanism at a college that we also own without a regular to train our own workforce to fill the needs we have.

At the end of this, we put it all together, and we fundamentally shifted the way that we engage our payers. Right now, Caritas Christi, the majority of its commercial product is risk capitated. That's a dramatic deviation from where we were two years ago.

If I could encourage everybody here with a few words is that we did it in two years. It can be done. It's not easy. It is hard, but it can be done.

MODERATOR WEIL: Thank you.

SPEAKER ENOS: Good morning, Commissioner Morales. My name is Deborah Enos, and I am the president and CEO of Neighborhood Health Plan. On behalf of Neighborhood Health Plan, thank you for the opportunity to provide testimony as part of the hearings regarding health care provider and payer cost trends; and as part of the panel addressing solutions to mitigate health care cost growth.

Neighborhood Health Plan, also known as NHP, is a Massachusetts-based not-for-profit corporation with headquarters located in Boston. NHP is fully licensed by the Massachusetts Division of Insurance as a Health Maintenance Organization and has provided comprehensive services since 1984. NHP serves Medicaid and commercial members, as well as those covered by Commonwealth Care and Commonwealth Choice. NHP is one of the only two health plans in the state that participates in all aspects of coverage expansion under Chapter 58 health care reform. Approximately 85 percent of NHP's membership and related revenue comes from publicly-funded populations.

Central to the mission of NHP is to ensure that quality, affordable health care is being delivered to our members, and we strive to provide culturally competent health care and services to low income, underserved and diverse populations that cut across all race, ethnic, gender, age, orientation and disability spectrums.

Rising health care costs are a long-standing problem in our nation, and particularly in our Commonwealth. Contrary to much national commentary, the state's health care reform initiative, Chapter 58, did not cause health care costs to increase.

However, the unparalleled success

Massachusetts has achieved in expanding coverage through this reform has placed a bright spotlight on our existing cost problems. As part of the initiative, it was always intended that cost would be the necessary and subsequent Chapter in our story, Health Care Reform 2. This intention was codified under Chapter 305 of the Acts of 2008 which, among other steps, required the hearings that we are having this week.

The results of two distinct and separate state-sponsored reports were made public. The first report, sponsored by the Division of Health Care Finance and Policy cited increases in rates charge had by hospitals and other providers as the major reason for rising insurance premiums. A similar report by the state Attorney General's Office concluded that provider rate increases were responsible for rising health care costs and that those increases were driven by the market clout of certain providers, not the level of quality of care they provided.

In our state, 90 cents out of every dollar of health insurance premium collected pays for provider-related health care services. This is an aggregate statistic. For some health plans, depending upon their mix of members, that proportion is even higher. Health plans like NHP that serve predominantly public-funded populations, recently report that the proportion of premium spent on these health services is even higher, as much as 95 cents on the dollar.

Reversing or even slowing the rise of health care costs is a complex task. Our current predicament did not evolve overnight, and we will not free ourselves from it that quickly either. Comprehensive, structural change is needed throughout our health care system.

Last year, I was privileged to be selected to represent the Massachusetts Association of Health Plans on the state-sponsored Special Commission on the Health Care Payment System, more commonly referred to as the Payment Reform Commission. I joined my fellow commissioners in demonstrating unanimous support for the recommendations of the final report that "global payments with adjustments to reward the provision of accessible and high quality care become the predominant form of payment to providers in Massachusetts within a period of five years."

This historic vote took place on July 16, 2009. We are now eight months into this five-year period, and it is unclear, at best, what if any progress we have made toward the goal. While we may not be able to predict with absolute certainty the impact of payment reform, we can predict with 100 percent certainty that we'll never get there if we don't start the process.

A comprehensive plan for implementing the recommendations of the Payment Reform Commission should be developed as soon as possible. Such plan should include the establishment of a successor entity to oversee the implementation; and the development of clear and measurable performance goals and benchmarks for monitoring the transition and for reducing state per capita health care costs.

The work to develop and implement this five-year plan needs to begin immediately, but there is also a number of short-term measures that can serve to reduce health care costs which can be acted upon with more immediacy.

One such measure is the legislation filed by Senator Richard Moore and Representative Harriet Stanley and supported by the Massachusetts Association of Health Plan of the Affordable Health Plan.

The Affordable Health Plan would provide rate relief to small businesses by limiting provider reimbursement rates, which is the underlying reason for higher insurance rates, as well as health plan profits. The affordable health plan could be brought to market this year, and could yield savings for small businesses of up to 22 percent over current premiums.

Another short-term option is greater use of high value, select or limited networks by private and public payers. The unwarranted variation in costs and quality across the provider community is well-known and documented. State regulations and policies, the market power of certain providers, and the lack of transparency of intra-provider contractual arrangements make it difficult to offer select networks based on the quality and efficiency of the doctors and hospitals.

Steps that can be taken to alleviate this situation include the easing of current regulations by the Division of Insurance which restricted the ability to promote limited networks, greater transparency regarding intra-provider contractual arrangements, regulations governing billing practices of geographically dispersed provider entities, and the elimination of all or none participation requirements in health plan products imposed by providers.

In the commercial insurance space, use of select networks can be encouraged by variations in product design and member financial incentives in the form of copayments, for example. In the publicly-funded health care arena, the use of financial incentives is largely unavailable and not allowed, for good reason given the economic constraints and challenges of its beneficiaries. In this instance, it is imperative that the emphasis on quality, value driven delivery systems be reflected in public policy.

There are several additional actions that could be taken in the short-term that would impact the trajectory of health care costs. Those include a moratorium on new mandated benefits, and repealing those that are no longer effective; strengthening of the DON process to include certain outpatient services and ambulatory surgery; support for demonstration initiatives and pilots which focus on achieving the goals of payment reform.

Once again, Commissioner Morales, I would like to thank you for the opportunity to be a part of this important hearing process. On behalf of NHP, I look forward to working collaboratively with you, other policy leaders, my health plan colleagues, our providers, members and the business community to insure a sustainable, quality health care delivery system that the residents of Massachusetts so greatly need and deserve.

SPEAKER GOTTLIEB: Good morning, Commissioner Morales and other members of the panel. My name is Dr. Gary Gottlieb, and I am the president and chief executive officer of Partners

Healthcare. Partners Healthcare is a nonprofit organization, employing more than 50,000 individuals.

I want to thank you for the invitation to participate in this important public conversation. As we open this dialogue on solutions, let us keep our focus on the priority, how best to deliver care to patients, their families and our communities.

We want to be a partner in an examination of all possible solutions. Today I am here to offer new ideas and reinforce attributes of others. Our collective mission is to prevent illness, disability and disease and to heel and treat the sick and injured while working to ease pain and find cures.

The health care system has evolved over nearly two centuries with emphasis on diagnosis and treatment rather than prevention and ongoing care. Public and private insurance models have been designed to indemnify individuals from catastrophic costs through sharing risk across broad communities of people, with budgets generally established based on historic costs and actuarial underwriting. The paralegal and seemingly unrelated design and pricing of employer-based private insurance and public programs result in unintended risk sharing and cost shifting among payers.

Moreover, unfettered fee-for-service payments have rewarded high insensitive care of the seriously ill and the rapid dissemination of advanced technologies. These payments have also created the need to cross-subsidize the under-reimbursed care of people with complex chronic illnesses.

Therefore, a narrow analysis of commercial insurance premiums and prices provides modest guidance to a more complex problem. Unlike a retail commodity, prices for individual health care services reflect a complex web of interactions aimed to support the costs of a broad array of services and activities, some of which may not be reimbursed at all.

The greatest opportunity for rapid cost reduction is also potentially the most humane, patient and family centered. Analysis of Medicare data shows that 10 percent of beneficiaries account for approximately 70 percent of costs.

These individuals are severely ill, suffering multiple medical comorbidities, and many are near the end of their lives. A good number are also Medicaid eligible. Social, economic and behavioral challenges often complicate effective medical care and add significant costs. Every employer-based insured population has similar groups.

Under the current health care system, care for this population is generally fragmented, addressing immediate and specific demands and circumstances rather than the whole of their personal and family needs. The absence of coordination results in care that is unplanned and reactive. Care is also often inconsistent with best practices, patient centeredness and the most effective use of resources.

Therefore, developing and implementing innovative approaches to managing the proper care for this vulnerable patient population is crucial. Even modest improvements will lead to a significant reduction in costs, reducing both commercial and public payments. But even beyond the potential financial impact, we should be doing this because it is the right thing to do.

There are several examples of successful programs which should be evaluated and rapidly scaled so that mesh usual improvements and cost savings can accrue in a timely manner. 1., for several years, the state's Senior Care Options program has combined Medicaid and Medicare funds for high risk dual eligible patients to centralize resources to improve care. Through this mechanism, Commonwealth Care alliance has developed a terrific model which has improved the quality of care while accruing significant savings.

Massachusetts General Hospital is in the third year of a Medicare demonstration project, which is managing care for 2,500 high risk Medicare patients under a shared savings model. The program has embedded case managers in primary care offices who follow these patients and try to help them solve problems before they become medical emergencies.

MGH invested in this and other care

coordination infrastructure and agreed to pay for it out of savings achieved by more efficient, effective care of their patients. They have succeeded in both improving care and accruing savings to the Medicare program.

The demonstration project has been renewed with expanded enrollment and is rolling out to Brigham & Women's Hospital and North Shore Medical Center. We're currently evaluating whether aspects of this approach could be applicable to a commercial population for implementation more broadly.

The prevention and access to care and treatment program, or PACT, is also focused on high-risk patients, but a different population, isolated low income HIV/AIDS patients. Based on the work of Partners in health in Haiti and Rwanda a, the PACT program in Boston employs tightly supervised community health workers to provide and coordinate care for these patients who struggle with their daily care needs and who access the health care system sporadically and expense civil.

PACT workers develop strong

relationships with patients, accompany them to appointments and provide or arrange for home-based services. The results of this program to date are promising, reduced hospitalizations and reduced overall health expenses based on our experience with 230 patients enrolled for at least one year.

In January, in collaboration with Commonwealth Care Alliance and Network Health, the program was expanded to focus on the care of about 1,500 chronically ill people with diabetes and other disorders who have been using the most resources in Network Health's Cambridge and Somerville population.

Potential solutions to our collective challenges come in many forms. Some of the programs I have highlighted are either growing or maturing. Here are some ideas that can be implemented more rapidly.

Fee-for-service contracts should have a reasonable component of reimbursement connected directly to performance measures tied to outcomes, quality and patient experience.

We should examine bundled payments. A

single risk adjusted payment would cover the costs of clinically-defined episodes of care, which can be chronic or acute. These payments cover the full range of services needed to treat the patient, including hospitalization, physician services, rehabilitation services and re-admissions for the same condition.

Bundled payments create an incentive for hospitals, post acute facilities and physicians to coordinate care, and also provide an opportunity to engage patients more deeply, especially those with chronic conditions.

They also require major changes for both providers and insurers. In order to implement bundled payments, insurers and providers need to be able to develop adequate bundled payments, and employers need to consider changes to their benefit designs.

An increasing number of bundled payments can serve as a test run for capitation, as these have similar incentives and require cooperation among many providers. Bundled payment strategies could save from $685 million to $39.3 billion over ten years.

And as a final step, if interim evaluations indicate its feasibility and advisability, the system should consider moving to a gradual broader adoption of global payments. Provider organizations would be paid a fixed risk-adjusted payment that covers all the costs of care for a certain period of time for a population of patients. As with bundled payments, insurers, and providers need to be able to develop adequate global capitation payments and employers need to change their benefit designs.

Strategies would also need to be developed for managing risk issues, as insurance risk would be shifted from insurers to providers. Many decisions would need to be made about what level of provider risk is acceptable and what level of reserves need to be held. Providers would need to be able to successfully manage the risk that they hold under capitation, including what care their patients receive, when they receive it, and from whom.

Capitation allows for the least amount of patient choice. Therefore, we all would have to prepare the public to accept some limitation of choice in exchange for the quality and cost benefits.

Lastly, we must guard against the perverse incentive of capitation to do less, a complete reversal of fee-for-service and no better place for the patient.

And as with any new initiatives, we must measure their effects comprehensively. Robust evaluation is critical. In all of these efforts, our main focus needs to be what is best for our patients, how can we help them manage their care effectively and efficiently?

I will conclude by saying that none of this work to transform our health care system can be done alone. Just as our health care system developed over time, and just as we all share some responsibility for the continued growth in health care costs, whether it is through how we provide, how we insure, how we purchase, or how we consume health care, we, providers, insurers, employers and consumers, and the government, all share some responsibility for finding solutions.

We believe that a shared approach, which will require change and sacrifice from all of us, will be the key to the successful transformation of our health care system into one that focuses on value for the patient, their families and the communities we serve.

Again, thank you for inviting me here today. We look forward to continuing this important conversation.

SPEAKER GRESHAM: Good morning. My name is George Gresham. I'm the President of Local 1199 SEIU, United Health Care Workers. I hope that I'm able to be able to be understood and speak clearly today. This morning, I bit my tongue, and I know that's unusual. People don't believe that. They believe everybody bites their tongue. I'd like to get started.

Thank you Commissioner Morales for the opportunity to testify on these very important issues. As a union of more than 350,000 health care workers, we provide care in a wide range of settings. Our mission is to improve and expand quality patient care.

We also have the capability for adequate funding towards the delivery of that care. As caregivers, we hope to offer a unique perspective in this discussion about strategies and policies to control rising health care costs.

Fundamentally, we agree with most other stakeholders that Massachusetts must act now to slow the rapidly rising cost of health care. Also, we must act now to ensure the success of health reform.

There are three key barriers faced in Massachusetts as we seek to control health care costs today moving forward. 1, the lack of workforce training and planning; 2, the behavior of insurance companies, particularly with regard to their reserves and rising administrative costs; and 3, a chronic underfunding for providers at the state and federal levels.

First we want to address the role of workforce training and containment costs. 1199 and its members are committed to continuing to improve our health care system in Massachusetts by the efficiency of care. We are committed to doing this without sacrificing quality of care.

We are advocating for a system of wellness to replace the current system of illness. High turnover rates and aging population and the lack of training programs to ensure workforce readiness are causing significant health care workforce shortages. These factors are also adding unnecessary costs to our health care system.

Massachusetts must develop a statewide system to identify how our health care workers can deliver more efficient and more cost-effective care. Through comprehensive training programs, we can then shape our workforce to meet those goals. Investing in workforce training and retention programs is a cornerstone in improving quality, health care delivery.

I, myself, started out as a rank and file member. And through the 1199 training and upgrading program, I became an MRI technologist. I took classes, and I rose through the ranks. We have many members who have utilized this training and upgrading fund to advance their careers and education to become LPN's, RN's, physician assistants and even medical doctors.

1199 is ready to work with the Governor

and the Department of Labor and health care providers throughout the state to build the health care workforce of the future. It is urgent that we build a health care workforce ready to tackle the cost and challenges of treating chronic diseases.

Current approaches to chronic disease management are major cost drivers and are having negative consequences on the quality of life experienced by our patients. Nationally, we spend 80 percent of our health care dollars on roughly 20 percent of our patients. These are patients living with diabetes, congestive heart failure, high blood pressure and other chronic illnesses.

We can lower the overall process of chronic disease and improve patient outcome by allowing patients to remain in or to return to their homes with the help of community health workers. Meanwhile, the reports prepared by the Division and our own experience leaves us with serious questions about the role being played by insurers in the Massachusetts market.

During my years at 1199, we have

consistently served an aging and sicker population, and we have witnessed many advances in medical technology and an expanded range of services. Expanding medical costs have driven overall health care costs at a higher rate than inflation.

However, the question remains unanswered. Why have non-medical administrative costs for insurers been consistently increasing at the same rapid rate? Why are the increases in insurance payments both to our members and for our employers so dramatically based in increases to payments which hospitals receive from these very same insurers?

It is worth noting that long-term payment reform will also likely include additional risk shifting, risk shifting from insurers to providers.

Insurance has built billions of dollars in reserve from patient premiums. We believe excess insurance reserves should be used to establish a new provider risk pool. Certainly, any new system must protect the financial viability of individual providers and new accountable care organizations.

Simultaneously, we must address the crisis of premium costs in the small group market. If insurance cannot meet the need of providing affordable insurance to small businesses, we should consider expanding the role of the Connector in this area.

MODERATOR WEIL: If I could ask you to reach your conclusion quickly.

SPEAKER GRESHAM: Thank you. Finally, Massachusetts must address the chronic and growing underpayment by Medicaid, Medicare and other public insurers.

SPEAKER LOPEZ: Good morning, Commissioner Morales. My name is Dr. Richard Lopez, and I am Chief Physician Executive for Atrius Health, an alliance of five multispecialty medical groups that includes Harvard Vanguard Medical Associates.

I will be testifying today on behalf of Harvard Vanguard, a not-for-profit 501(c)(3) tax exempt organization providing comprehensive primary and specialty care from 21 locations to nearly a half a million patients in approximately

2 million office visits annually. Our 629 physicians and their medical teams are dedicated to bringing a broad range of patient-centered, coordinated services to our communities and making it easier for our patients to be healthy.

I am honored to be here to discuss strategies to mitigate health care cost growth. We recognize that the rate of growth in health care costs is not sustainable and that resources already in the system must be put to better use to contain costs.

Harvard Vanguard takes seriously our responsibility to be a leader in finding ways to be more cost-effective and simultaneously to increase quality for our community.

There must be different approaches for containing costs in the long-term and the short-term. Chapter 305, with the establish the of the Payment Reform Commission, recognizes the need for long-term solutions that center on economic models that provide incentives for continuous improvement in both quality and costs.

The commission recognized the inherent difficulties with fee-for-service payments that reward increased volume and the associated increases in cost. We must pursue the direction that they recommended to move to global payments with quality incentives.

However, we cannot wait the likely five or more years until these important changes can be implemented. We must stem the rise of costs in the next two to three years, and we recognize that the government may need to take a role in making this happen.

We believe that the right balance between short and long-term strategies will be found by implementing the short-term strategies that will not derail our longer term goals. Reducing costs is possible and needed, but cannot be done in a way that is drastic and has unanticipated consequences in the longer run.

In the long-term, there are two strategies that we believe will be most effective in creating an economic model with the right incentives to drive down costs.

Promote global payment to accountable care organizations. We agree with the Payment Reform Commission's recommendation to move to paying accountable care organizations a global payment that is an appropriate amount of funding for the care of a population of patients with incentives for the quality of care delivered.

Harvard Vanguard, which is given top scores when quality is independently measured, currently receives global payment for about half of our funding, accepting full risk for the care of our patients, including care provided at hospitals, other specialists and for pharmacy expenses and imaging.

Primary care physicians with established relationships with their patients coordinate care to eliminate duplicate testing, to support the patient in receiving care in the most appropriate setting, and to ensure that care is managed across the continuum into the hospital and beyond. We know that global payments can help providers better allocate limited resources toward care that will ensure the best health outcomes.

Redesign health plan products to better link choice with cost. Many patients are insured with products that do not require selection of primary care physician and that allow for choice across a network that includes most of the providers in the state. Without a primary care physician, these products result in fragmented care and allow patients inadvertently to select more expensive settings when the same procedure or test might be done elsewhere for less with the same quality.

It is critical to ensure that patients are better educated and have more at stake when choosing more expensive venues for care. We believe that we all must participate in sustained efforts to educate employers and patients about the cost of health care and the role that their choices play in increasing costs.

We also must work together with payers to structure products that provide more incentive for appropriate care. It should be noted that PPO's are not designed to work with a system of global payments and currently limit Harvard Vanguard's ability to accept predominantly global payments.

There are several shorter term strategies that are in line with the

Commonwealth's longer term goal of moving to a new economic model for health care and that should be considered to address expeditiously the current level of costs. These short-term strategies focus on ensuring that the right care is provided in the most appropriate and cost-effective setting.

Ensure viability of critical and cost-effective hospitals. Hospitals such as the disproportionate share hospitals and some of the community hospitals have developed specific experience and skill in caring for a population of patients with diverse and often very expensive and complex health needs in a cost-effective way. It is critical that these providers are protected in any short-term measures taken by the state to address costs.

These providers offer the appropriate venue and alternative to care at higher cost tertiary hospitals. Without the continued viability of these providers, the Commonwealth will be unable to develop low cost accountable care organizations in the longer term.

Shift care into high quality lower cost

ambulatory settings. Harvard Vanguard is actively moving care into the ambulatory setting. In that way, we will access lower fees for many services and procedures that are not differentiated in quality from care provided in the hospital.

However, it would be difficult to move the whole market in this way quickly. We believe that the Division should evaluate establishing the same total rates for selected high volume ambulatory procedures regardless of whether they are performed in an outpatient setting or in a hospital.

We agree with the Division's recent reports that wide variations in rates for the same procedures add considerably to overall cost with little or no correlation between quality and patient outcome.

Select networks. We believe it is possible to quickly construct select networks consisting of alliances of high quality providers and hospitals that are currently capable of accepting and sharing risk and providing care in global payment environments to patients, employers and other payers that are willing to accept these networks.

This approach could accelerate the move toward ACO's and global payment. We believe that, with appropriate benefit design, these products could be offered below the current average prices for unrestricted PPO products or self insured fee-for-service programs.

Harvard Vanguard believes that these are among the many possible strategies that we can employ in the Commonwealth to tackle this issue both in the short and long-term. As we continue our own efforts to bring down our costs of care, we remain committed to working with the Division, other state policymakers and our colleagues in the health care industry to examine and implement the right strategies to address rising health care costs.

On behalf of Harvard Vanguard, thank you for allowing me to participate today.

SPEAKER MITCHELL: Over the past ten years, I have often felt like a cross between the Prophet Jeremiah and Chicken Little. Along with a small group, mostly purchasers, we have been talking about cost, while most people in the health policy field were talking about quality measures and wellness and pay for performance and transparency and making patients have "more skin in the game," all of them carefully avoided using the P word. So I welcome these hearings and the reports from the Attorney General's Office and the Division of Health Care Finance and Policy talking frankly about contracts, prices, compensation and even about the uses and misuses of market power.

Although insurance companies, whether nonprofit or for profit, are considered fair game, these have not been comfortable topics when applied to physicians and hospitals. I applaud the Governor's initiative, and the Attorney General's report, particularly as they apply to provider contracts, a black box whose contents have been zealously kept hidden from us purchasers, except when the plans ask us to pay for the contents.

Last year, the GIC spent $1.3 billion of taxpayers' money on health care along with another $250 million in employee premium contributions, and approximately 90 cents of every premium dollar went to pay providers. Just two weeks ago, the commission authorized rate increases of close to 8 percent, or 4.7 percent higher than last year's increase.

Last year's increase turned out to be insufficient to cover this year's spikes in utilization and significantly, prices. Facing the grim reality that our FY 10 spending was going to outrun our appropriation at the same time that tax revenues were plummeting, the commission took the painful and rare step of increasing copays and instituting an up-front deductible in the middle of a plan year.

I do not recommend this as a way to win friends or to influence people. A lot of people claim that it is the patients that are the problem. Many of us do eat too much, exercise too little, and have a love affair with the latest technology.

People still believe that unlimited choice of providers is good, that more treatment is always better, and the most expensive treatment is surely the best, whether or not the evidence suggests otherwise. I would suggest that constant, expensive advertising on TV, radio, billboards and direct mail has helped create these beliefs and fed the demand for more and more intensive utilization.

So, what has been tried, what has not worked to control costs. Pay for performance, the GIC has never participated in these widely used programs, believing that, as our budget demonstrates, we are already paying more than enough. Why should be pay more? These programs have had no effect on costs.

Disease management and related programs, the studies show similar patterns. The patients may benefit from these programs and the companies that offer them may make money, but for cost control, over time, these programs have not stopped inflation.

The Adam Smith option, namely, let the market work its so-called magic, what the Massachusetts market has wrought is consolidation, market domination and wildly different prices for the same services.

Transparency, of course we support

efforts to bring consumers information about prices and quality, but the effect on costs would appear to be minimal.

Whether it is the power of inertia or the complexity of the data, unless regulators or purchasers are prepared to attach serious financial consequences, making patients pay very heavy penalties for choosing more expensive providers, the publication of prices doesn't affect choice in any meaningful way.

So what might work? For starters, I hope the legislature will work with the administration to set up a structure for public examination of rates and their underlying contract provisions, including a review of the contracting provisions described in the Attorney General's report.

My agency is happy to be part of the solution rather than part of the problem. We have been profiling both physicians and hospitals, for quality and cost for four years now. And we attach admittedly modest financial consequences to the results, while maintaining choice for consumers.

This year we are offering limited network options in all three of our largest plans with premiums 20 percent lower than their full choice alternatives, and the most expensive providers are not included in these plans.

Our intention is to market these plans, to grow them, and very frankly, to stir up the market and send a very strong message to providers that neither the taxpayers nor the enrollees can afford to sit by and watch costs just go up and up and do nothing about it. Choice has traditionally trumped cost, but maybe it's time to challenge that tradition.

We support the special commission on payment reform's goal of ending fee-for-service and substituting a global payment cyst at the point. We have a chance to get a capitated system right this time. And frankly, speaking for myself, not the agency, I personally would support some variant of rate setting, possibly temporary, if we can't get our arms around the cost monster any other way.

Massachusetts, with its intellectual fire pour, its history of managed care, its not-for-profit networks, and its commitment to provide affordable care for all its citizens could, once again, show the nation that we know how to do it. All we need is the will to make it happen.

SPEAKER ZANE: Good morning, and thank you for this opportunity to testify with some of my very august colleagues and for the opportunity to discuss strategies to mitigate health care cost growth.

I would first like to commend you, Commissioner Morales, Governor Patrick and the administration officials, the Attorney General and the legislature for recognizing this critical issue and for taking action to address the problems in one of the Commonwealth's most important industries, an industry that creates hundreds of thousands of jobs in the Commonwealth, an industry that is regarded among the nation's finest.

I would specifically like to commend you and the Attorney General for the reports you have produced which have very astutely pointed out the areas where we need more scrutiny, transparency and change in our course of action.

The AG and DHCFP reports demonstrate how market pricing disparities, consumer behavior, employer demands, health plan practices and government underfunding all play interrelated parts in the cost trends we are experiencing.

To address these issues and move forward in a manner that ensures high quality health care for all of our citizens and a strong and vibrant health care industry, I believe we must look into integration, provider care in the most appropriate location, limited network products, government payment.

Creating a truly integrated system. I have gained many years of experience learning to integrate doctors, the services they provide and hospitals. And I can tell you, it's not easy. There's no silver bullet and one size doesn't fit all. It certainly doesn't happen overnight. There is a great deal that goes into meeting the goals of better quality, true integration and savings in the long run.

I believe there are innate perverse incentives in the current fee-for-service system and that global payments will better align incentives, thus facilitating integration. However, global payments, in and of themselves, will not address the underlying problems.

It is very important to understand that a low cost fee-for-service provider will have a much lower cost trend than a high cost globally paid provider. If we bake in the current market inequities, we will have accomplished nothing.

MODERATOR WEIL: I want to thank the panel for a great way to start this conversation. My job is to keep us focused on what to do about the problem that brings us here today. And so I want to, as I did with Dr. Altman, begin with sort of the long-term and make sure we have a sense of where we want to go and then try to pull back to see what we can do to get us there.

Let me just ask a simple question, and a number of you alluded to it. Is there anyone on the panel today who does not endorse at least the broad objectives of the payment changes recommended by the Payment Reform Commission?

So I'm going to take by your silence that that's an agreement. Again, I understand there are many details to be worked out. It's an agreement on a vision for where we want to go.

Dr. de la Torre, you began by telling us what your organization has done to move in the direction of being ready for that. What I would like to ask you, although it may be the easiest for you and the others, is to tell us what your institution or organization needs to do to be ready for that shift and what specific public policy change you would find most beneficial to preparing yourself for that shift?

SPEAKER DE LA TORRE: Okay. So I think, by telling you what we did and we want to do it, we really had to wholesale change the way our physician, our entire contracting network interacted with our hospital system.

I mean, we have a fairly large hospital system of 70,000 admissions, 275,000 EE visits, over a million physician encounters a year. So our contracting network expands well into non-employee physicians. The vast majority are non-employed.

We had to completely revamp our contracting network to accept risk and dispense risk throughout our system. We have to bring our individual hospitals within that system to accept that risk with the physicians. This conglomerate then had to invest in a tremendous amount of infrastructure, both IT and Manpower infrastructure. It's about case management, referral management. It's all of those things. We had to put those boots on the ground.

Then it required massive IT infrastructure. We converted every, single hospital in our system not only to advanced clinicals, but full CPOE. We're completely paperless as of next month.

Every one of our hospitals, every one of our physicians we supplemented the cost of their electronic medical records in their offices with the combination of some of payers so that it's basically good for them. That's 1,200 that we're deploying. Then we felt that we needed to go the next step which is tie it altogether.

We contracted with Microsoft to come in with this Amalga product and literally tie all of our point of care hospitals, all of our hospitals, all of our physicians together into one massive share database. That's what we needed to do.

It required bylaw changes and reorganization of our hospital system. It required a lot of IT, and it required a large management infrastructure

MODERATOR WEIL: So what is the public policy role in supporting that shift, if you hadn't gone through it, or sustaining that shift in a new world?

SPEAKER DE LA TORRE: I think it's to incentivize it. You need to incentivize the providers and in some cases providing financial means to achieve this. If I were to say -- we talked about limited networks, for example. Limited networks won't do any good if the limited network exists within a structure of a HMO.

All you're doing is disbursing your cost savings throughout a network that absorbs those cost savings and just passes it on. You also have to be careful with limited networks not to, quote unquote, bake in cost discrepancies.

There is a sad truth which is that if you look at providers, there is a lot of cost discrepancy. There's even a sadder truth. If you map out those cost discrepancies by individual physician providers, i.e., through utilization, you'll find a pretty substantial socioeconomic disparity in Massachusetts.

So we have to be careful not to bake those in as we roll this out. Now, when you roll this out, you have to be careful in limited networks that you price them. I think Dolores alluded to the 20 percent savings. The problem is that if you're covering 80 percent as an employer of the cost of whatever program somebody picks, if you save 20 percent, then you're only saving 4 percent difference on the patient.

That's all they're getting because you're picking up 80 percent of that 20 percent. That does not create enough of a discrepancy in pricing to make people choose. So let me give you an example.

We created a limited network product for your employees. The year before it was percent of premium pricing, and 100 people chose it. We have an HMO that is a limited network. However, we priced it on a defined contribution. To say, okay, we'll give you this one for almost free, it cost employees no deductible, no copay, 6,000 members enrolled in one year. It kind of stretched us a little bit, but that's because we were able to set the economics of the program to make people realize what the difference was, and percent of premium doesn't do that.

MODERATOR WEIL: So that was a choice you could make without any external policy intervention. I'd like to hear from some others about the steps you need to take to get there and what you need in public policy to make that possible.

SPEAKER ENOS: Sure, and I'll start first with the public policy. As I mentioned before, Neighborhood Health Plan has 85 percent of our members and our business publicly-funded. To pick up on the last comments of our colleague, Ellen Zane, I would say the No. 1 public policy issue that is important is the adequate funding for those public populations.

We can form select networks. We can do global payments. We can do a variety of things. If the amount of dollars are so inadequate, it really will not work. So that's the No. 1 policy that we need a comprehensive and rational strategy of how we're willing to pay for our public funded programs.

Secondly, with respect to the networks, interestingly, Neighborhood Health Plan was founded by the Massachusetts link of committee house members over 20 years ago. So in essence, we, although we have many providers in our network, we were really founded and our purpose which still exists today is to serve a very particular population.

So by definition, we operate somewhat with a limited provider network, particularly through primary care between the community health centers and other centers such as Harvard Vanguard. 80 percent of our members get their care, their primary care in those types of settings. So structurally we have that.

For us, what we have to do and what we did do is to work with our other sort of provider colleagues with respect to other types of services. It's interesting when we talk limited network and patient choice and patients to have incentives, and I firmly believe in that, but we're faced with an interesting phenomena in that our members tend to live in particular areas, in urban areas of Boston and other cities, and they tend to live in areas that are very much predominantly by teaching facilities.

Those are their community hospitals, and they do not have the mechanisms to drive and transport themselves otherwise. So it's imperative upon us, we have to make those arrangements work and work within a reasonable financial sort of considerations. And so there are partnerships.

I say for many at this table that we have developed around that. What I would say is the key, really the key issue is the funding. That is the issue that is most important and that woefully inadequate at this point.

MODERATOR WEIL: So let me push a little, and I'm going to turn to Ellen Zane on this topic as well. I think it is clear that there's an infrastructure necessary to make a transition. That infrastructure costs money.

What's not clear is money will be

translated into the infrastructure. How is it that if you get more resources, the Commonwealth can feel confident that those resources are going into the development of this more efficient system as opposed to the kinds of variation that at least many of the folks over the last few days have expressed is not associated with events like that?

How can we, how can you convince the policymakers that when, or how could you structure the financial resources that you feel you need to make that transition in a way that they could feel confident they're getting what you're trying to provide?

SPEAKER ENOS: Sure. Well, I'll start first as a health plan. In days when we are able to do reasonable financially, part of that is investments in the core primary care network. And there are numerous instances where we have done that throughout the years and worked collaboratively to do that. But the other has to do with the nature of the financial arrangements.

And I think what is critical in some form of global payment, be it actual payments or arrangements around budgeted targets, what is critical is that sort of savings that are incurred in other parts of the system are able to be at least partially reinvested with those providers and other entities that are generating savings.

So one of the very classic examples has to do with we all talk and lament about unnecessary emergency room utilization. So there are a number of programs and different things that a health plan can do to effect that. But what happens in the absence of a financial structure that loops that together is that the health plan might say if we are to reduce emergency room utilization, but what does that do for the provider who presumably has had some role in that?

That's a system on just a microcosm by an arrangement whereby savings that are targeted, sort of emergency room utilization, that there is a mechanism to sort of invest some of that back toward primary care.

MODERATOR WEIL: I'm going to push one more time and say I do understand if you generate savings or have revenues, you can reinvest. My question is, How can you be held accountable to the citizens of the Commonwealth that when you have those savings for resources that you will reinvest? That's what I'm looking for. Does that difference make sense to you?

SPEAKER ENOS: I think it can. I think it does. In terms of accountability, I think -- well, I will say what happens in our example, very clearly, it's very clearly demonstrated in sort of financial reporting so to speak. So if there are dollars, there are reports that follow all providers. There are reports that are generated that we provide to our board.

There's many, many hundreds of reports that we provide to different state agencies. And I think it would not be at all difficult to show utilization, cost against budgets, what the actual results were and what happened to those dollars.

MODERATOR WEIL: Thank you. I'm going to jump to you to give us a similar set of thoughts about the accountability.

SPEAKER ZANE: On your last point, the

accountability?

MODERATOR WEIL: Yes.

SPEAKER ZANE: I don't believe -- I'm going to take a little bit of a different approach. I don't believe the state can promulgate how the albatross dollars are spent. I believe the way we need to look at it is we have a fix we need to do first.

We have a very unlevel field here that doesn't correlate to quality and doesn't correlate it to outcomes and doesn't correlate to acuity. We have to fix that by somehow leveling that to some degree somehow. Then we have to provide incentives like bundled payments, like global payments, like latter day capitation and say to providers, you must have certain kinds of outcomes. And you are going to sink or swim relative to your ability to perform.

That inherently will give providers the incentive to do the right thing.

MODERATOR WEIL: Is that fix a rate fix alone, or is it the state paying for infrastructure?

SPEAKER ZANE: I think every payer has to pay for this infrastructure. We all sit and talk about infrastructure. It's kind of a fuzzy term. When you push people and you say, well, what is infrastructure, the typical answer we get is IT. IT is very, very important, but it is not just IT.

It is care managers. It's pharmacists. It's actuaries. The infrastructure we need to appropriately not fly blind in a capitated or global payment type world is very extensive. So every payer needs to understand if they want us to be globally capped, they have a responsibility to partially pay for what it's going to cost.

MODERATOR WEIL: So is the citizen of the Commonwealth who sees their premiums have gone up, thinks health care costs are too high, the first thing they're going to hear is we're going to spend more money to build an infrastructure for a better payment system?

Then the reason we know that money is being well spent as opposed to all the money we put in now which wasn't so well spent is people five years from now people who don't spend the money right aren't going to succeed in the financial system. I have a hard time figuring out how you're going to make that sale.

SPEAKER ZANE: We have to be realistic here. We are not going to flip from a fee-for-service system with no infrastructure to any kind of other system that requires infrastructure for that. Five years from now, we're going to be looking at a lot of damage on our path along the way.

I think Mike Whitmore did a very good service in the Globe the other day when he wrote his op. ed. piece about really what we're looking at and what it's going to take. So we have the fix we must do first in order to fix the disparities in this market. That should help.

But let us be clear. We have to invest as well, or this isn't going to work. And it's going to be a fair amount of theoretical hyperbole.

MODERATOR WEIL: Dolores.

SPEAKER MITCHELL: I want to remind you of another P word nobody uses these days. It's called planning. There was a day in which all over this country it was tried. I know everybody will say it didn't work. It didn't work; so therefore, we shouldn't do it again.

There's also a theory that says if you just do the same thing the last time all over again, have you no right to expect different results. We've learned a lot in the interim. There are some techniques that could be applied.

Simply reviving determination of need whose sad history I can recall by itself would have, I think, some perverse incentives because the people who are already there will get advantage. And the people who aren't yet there are going to be told no, you can't have it. So that won't work.

But you can structure a determination of need program of some sort in which you can give assistance to communities or to provider groups or to hospitals or to community health centers to get them either bond preference or loans or some other kinds of financial mechanisms to enable them to do the infrastructure kind of things that would be over and above IT.

I think there has been absolutely no discussion about that as a possibility, but there are some other things we can do that are low-tech and probably low cost. I mean, we ought to be encouraging greater use of mini clinics. We ought to be using greater, the great capacity we have in registered nurses as primary caregivers. Beginning to happen, but should be accelerated in my view.

Something as simple as palliative care and the enhancement of those programs, while it is usually thought of as a quality measure, is also a cost measure. There's a whole menu of things that we can do and should be doing that I think can have an impact on prices.

But I think the thing that I kept saying to the Payment Reform Commission that nobody wants to talk about is that unless the size of the pie gets bigger, there are going to be some winners, and then there are also going to be losers. You have to figure out how to do that in a way that is reasonable and fair and not punitive but, in fact, which moves the dollars in slightly different locations.

MODERATOR WEIL: So I want to get the three who've not had follow-up comments to relatively quickly give us your answer to what public policy can do to support your transition, your organization, your folks' movement into this new payment model. And then we'll pull back into some more concrete immediate steps.

SPEAKER GOTTLIEB: Sure. There are probably three things. One, as Dolores was inferring, really allow creative approaches to redesign the front end of care. Probably the great asset that we have here in the Commonwealth relative to most of our peers are well developed medical homes in community health centers.

They provide inadequate capacity relative to the need of the population. They can serve a much broader population than currently the community they're serving, substitution where there are shortages. The ability as I mentioned before in models that we've also been involved with as well as homeless populations, community health workers in teams together with nurses, care managers, and physicians provides an opportunity to substitute for very, very expensive services and really is an immediate pathway.

Right now, the payment structures don't

really allow for that relative inflexibility. And that would be critical. Second, I think that a real focus is on cost shifting and looking across where costs are and the decisions we've made and the ramifications for them. So if I said to you that I believe that commercial very high rates are paying for other kinds of services, they're paying for other services that are necessarily reimbursed.

Particular sensitivity to the notion that people, that we've taken peoples' behavioral health and diminished its importance over the course of probably two decades on the public and private sector side, on the commercial side we're paying less than 2 percent of premium for behavioral health services.

At the same time, people still have brains. They still have behavior. The complexity and the most expensive populations of the behavioral health needs are extremely high. We essentially have cross-subsidized about $42 million worth of losses in the largest behavioral health services in the state in order to be able to provide services where others have had to abandon them because they couldn't afford to deliver on their mission.

I think the definitions of complexity that need to be used in measurement of payment need to be critically focused. CMI has been a poor predictor for CMS. It hasn't been particularly valuable. In looking at complexity, we need to look across bundles so that we can create payment mechanisms that look at complex populations and pay appropriately across the spectrum of care.

When I look in your hospitals, and I was thinking about it when we talked about the tiered networks, about one in seven patients in the MGH, about one in eight patients at the Brigham are transferred from other hospitals. There's some set of complexity, quality or other care that seems to be necessary that we have the standby capacity, perhaps because of our commercial premiums, that we can afford to be able to have to do stuff that would otherwise lose a lot of money or being too expensive to have. Those patients account for, 12 or 13 percent of our patients account for about 40 percent of our mortality, very substantial losses.

So the notion of looking specifically at cost shifting, looking at complexity, redefining the front end and going to the accountability issue, forcing us to scale up programs that are very specifically focused on complex populations, the state has the ability to be more creative in a way that Medicaid and Medicare capitations could be aligned in programs like senior care options, to focus on being able to enable rapidly the payment for care managers and for some of the infrastructure where monies are otherwise wasted in the way that we're responding to the incentives as they exist right now.

MODERATOR WEIL: Mr. Gresham.

SPEAKER GRESHAM: Sure. I think that we, in order for us to really be helpful, we have to be a part of the system. We think that workforce development and training is something that really provides control over the costs of health care and the ability to provide quality and better quality and more efficient health care.

Dr. Bailit told me he talked about the fact that we've worked together in developing a training and upgrading program. I think if we want to make sure that health care in the future is provided in the most efficient and yet at the highest level of quality, then I think that has to be a model that is adopted throughout the industry.

Part of our problem, we believe that we're a value added organization. But there is obviously a concern when you regulate an organization, and that is you rise the health care costs up. In fact, we have a history throughout the country of helping to, helping institutions that we're a part of to maintain control of health care costs by working together with management and being innovative in how we can work together.

I must say in Massachusetts, if you'll excuse the pun, we like to partner with a lot more organizations and bring value added to that. But it begins for us, we can't be helpful on the outside. Our greatest ability to contribute to this, to help institutions to meet the accountability and the standards that we're talking about is when we work together collectively to do that.

MODERATOR WEIL: Thank you. And Dr. Lopez.

SPEAKER LOPEZ: Yes. Well, there are a lot of, there have been a lot of good ideas. I'm not going to repeat them. I would add a couple of things. One is I think it's important from a public policy point of view to educate patients on the cost of health care. I think this has been to some degree the white elephant that we haven't really addressed in the room.

The fact that really since the inception of indebted payments, third-party payments, patients have been divorced and sort of unaware of the impact of their choices and their decisions. I think this almost calls for a sort of public, sort of a public education campaign like we've done before in other settings around washing your hands or don't litter.

There are a lot of things where heavy sort of government education and providing information to health consumers about their choices and what is the impact and promoting incentivizing products, insurance products that really incentivize the patient as well as the providers.

The other point I would make is around, is around supporting community hospitals which we believe some of them are, many of them are cost-effective. And they, many of them are struggling. And it's a critical part of being able to deliver accessible health care at a low cost.

MR. O'BRIEN: A follow-up question to Dr. Lopez. Before I state the question, I also want to be, on behalf of the office, continue to thank everybody who has been part of this process. The providers at this table, each one of whom participated in our examination have been very cooperative. We appreciate that. Dr. Lopez in particular was very kind with his time in trying to understand the system. We appreciate that.

To Ellen's questions about the investment that's necessary. Atrius has, in fact, made these investments. It's put in its pre-filed testimony associated with medical management.

I'm sure Dr. de la Torre has similar

information that has come through the experience of building that network more recently, and you have a more established network of medical management and infrastructure. In the pre-filed testimony, it was actually Dr. Lindsay's submission, said $8 to $12 per member per month or 2 to 4 percent of HMO premiums.

Is that consistent with your overall investment, or as far as the investments that you do in order to make your infrastructure successful in managing both risk and performance?

SPEAKER LOPEZ: I think that 8 to $12 was based on some readily identifiable cost that we have. So we looked at, you know, case management, our clinical pharmacy program, some of the other managed care programs we have. So I think that's probably a minimum.

But in addition, and I think this is clarified subsequently with your office, you know, there are other embedded costs in our program that are a little bit harder to tease out. You know, for instance, we encourage our patients to sign up for our Internet portal so we can communicate with them readily.

They receive their lab results immediately as soon as their doctor receives them. There's a cost to doing that. We think it's an efficient way to practice medicine, but we didn't size that out.

Another example of costs like that could be the time it takes to rehab some health coaches on some of our sites or the time where our physicians probably see fewer patients per week than most in the community specifically because they spend that time on the phone, coordinating care and so forth.

So I would say that's sort of the minimum. And I think it's, I think our costs in terms of managing this is greater than that.

MODERATOR WEIL: So I want to focus us a little closer in. This has been a great set of ideas for long-term transformation as well as the cost containment aspect of it. We know from the Attorney General report and the data presented over the last few days that there is focus on price. And I would say it's relatively easy at least to say that we should start with some sort of a regulatory structure to freeze or recalibrate or something like that.

We can fight over, you can fight over the details in how that might be structured. But I want to ask the other side of it, which is, where can we use market forces in the current system for short-term savings on the price component? Is there a role here for market forces to bring down price? Who's prepared to make a concrete suggestion for a policy that would yield savings not just through a regulatory approach, one that comes to price?

SPEAKER DE LA TORRE: I don't know if this counts as regulatory or not, but I'll just note some ideas as everybody has been talking that come to mind. I speak with this as a system of community hospitals, five of our six hospitals are 340B DSH hospitals. We're in the realm as you mentioned earlier.

We didn't reinvent the wheel, okay. So I'm going though throw out ideas, not having thought about them much, but they may fly. How about we monitor rates and have the Commission monitor rates that are paid? And when I say monitor rates, you also have to monitor pay for performance because that's the way we shift rates around.

So you have to standardize that. But you create a fee, almost a luxury tax of sorts, but a fee for certain high-end rates. Use that fee that's pulled off the high-end rates to give money to the institutions that need infrastructure support. By doing this, you still allow hospitals to gain profit.

The way you can gain profit is with a capitated risk methodology. So they're going to make profits by saving money. So that's just one idea that came to mind.

COMMISSIONER MORALES: Ralph, could you explain tangibly what that would look like?

SPEAKER DE LA TORRE: Again, I haven't thought much about it. You create a system where you say, okay, we need to understand how the payers are paying the providers. We need to look at how pay for performance is, and we should standardize that as a state.

We should report infrastructure money. Money that comes through the back door, quote unquote, should be reported. I'm going to make up wild numbers. Let's say every dollar you get over 300 percent of Medicare as a fee, some kind of average schedule taking into account teaching and research and everything else, you pay 25 percent into a fund.

Anything over 350 percent of Medicare, again, made-up numbers, you pay 50 percent into a fund. You do that methodology, and you propose that on current rates. So that creates a pool of funding that is available for essentially some of these community hospitals that are really capital starved, so that we can begin addressing these issues in communities where it's a lot cheaper

MODERATOR WEIL: So I'm -- it's an intriguing idea, but I'm going to push my question which that feels like a source of funding of investment in the long-term system change that we've been talking about.

I'm really trying to figure out does the state have any tools in the short run to address what's been identified as the primary source of premium growth that are not rate regulation?

SPEAKER DE LA TORRE: How about the Department of Insurance re-up regulation so that accountable care organizations can create limited networks?

MODERATOR WEIL: So a limited network approach is one idea. We'll come back to that in a moment. Other suggestions?

SPEAKER ZANE: I was going to say, tomorrow we could start limited networks. We could start this tomorrow, and it doesn't require regulation. It basically requires that the market just be incentivized to do it.

Someone mentioned on the panel, Dolores, maybe it was you, the role of the consumer in this though. We really have -- there is a responsibility from a public policy standpoint as well as from employers for us to begin to educate consumers about their responsibility.

As I often said, consumers believe that they want what they want when they want it, and then they complain when it's not cheaper. There really needs to be an understanding that if we want to save on our premiums, there is a trade-off associated with that.

MODERATOR WEIL: Let's go a little bit down the limited network path. I guess I have a few questions about it, and I'm not going to suggest who should answer; although, that won't be a problem. Are we limiting on pricing? Are we limiting on some sort of quality metric? If so, how transparent can that be?

Is our goal merely pedagogical? See, we could really pay less, so it's your fault that the health care system costs so much because you're not picking the cheap option? Or are we really going to move cost dollars and give them resources to move in the accountable care direction?

I'm trying to figure out -- we heard yesterday with some limitations that we know of that the efforts at these networks to sell these products haven't been overwhelmingly successful. I'm trying to figure out what we think we're going to achieve by doing this; although, I appreciate that it's a non-regulatory way to do that.

SPEAKER MITCHELL: Can I comment on that because I'm just starting to this week or this month? What was our thinking in doing that? We are very acutely aware of what all the negatives are, that there will be adverse selection, that the only people who will join them are people who are twelve years old and healthy and run 100 miles a week.

And some of that will no doubt happen. But what we found and what we're banking on is that in the other plans that we have that already have such limited networks, Unicare has a Community Choice, it has only one tertiary hospital; and it focuses on community hospitals. And it was an uphill slide.

But the fact of the matter is, it has grown every year in enrollment. And there comes a point where people will, in fact, think long and hard about what the premium is compared to whether or not they want full and unlimited choice.

And our hope, and for those of you who are running hospitals, my apologies, our hope is that if we can get enrollment up high enough that our payers, and remember, I'm a purchaser, not a payer, that the health plans in going back to negotiate rates next year with their providers will say, excuse me, you're not in our network.

And guess why? You cost too much money.

And that will increase their leverage. Because I have to say, and again, those of you from health plans, my apologies, but you have not had backbones of steel.

I keep saying there's something wrong with this picture. I pay you millions of dollars, and the providers pay you nothing. They take those millions of dollars away. How come you're scared of them, and you don't care what I say or want? There's something wrong with that picture. I am trying to put a little cement in their backbones. That's what I'm trying to do.

MODERATOR WEIL: Ms. Enos.

SPEAKER ENOS: I'm scared of you, Dolores. You got one. Actually, quite the contrary, dear friend, with the most respect. With respect to limited networks and Ellen's comment that we could start tomorrow, I think we could.

There is a piece, and I don't know if you're considering this in the sort of non-regulatory. It has been some of a restrictive positioning with respect to how health plan products are sort of licensed by the Division of Insurance.

In order for there to be enough of an incentive for someone to pick the efficient network, so to speak, or a select network, there needs to be the ability to create enough of a differential in terms of that person's out-of-pocket payment, being towards copays, their premium contribution, et cetera. And there have been some sort of roadblocks with that.

So that is one thing that would need to be addressed. Hopefully that's not a huge sort of regulatory issue. But it clearly could. The other thing that I think needs to be addressed is something that I referred to in my initial comments with respect to sort of the transparency and understanding of sort an intra-provider contract arrangement.

For example, I may have all kinds of information to show me that this particular provider is going to be, have the characteristics to be selected. And I think that is the network I am picking. But because of sort of coverage, because of providers that operate in multi-settings, sometimes often geographically in different locations from where their main location is, in point of fact, you may think that you're contracting with a select value network only to find out that, you know, half of the specialists are really part of another network; and they bill you as though they're part of another network.

That clearly has to be addressed to really make this efficient. I do think limited networks could start quickly with that one twist. There has to be flexibility. One of the things -- and Dolores has wonderful health fairs, and all the plans go and talk to perspective members.

One of the things that's changing a little bit in our electronic world, but is still true, is how big is your provider directory? Some of them are the size of two Boston phone books. They don't want to look at it. It's just for security that it's that big.

The reality is you have one primary health care provider, and you'll use a few specialists; but the concept that it's very easy just for security sake just to have that whole book I think is one we have to reverse. I think that copayment on commercial and getting public, it has to be public policy and the publicly-funded entity.

COMMISSIONER MORALES: As some of you know, have you two of the most market-oriented commissioners sitting across of you. I'd love you to drill down more specifically what those incentives are specifically. I want to go into what Dolores talked about. For the insurers, what would those incentives be? For providers, what would those incentives be? I'd like to drill down on what those incentives are.

SPEAKER GOTTLIEB: There are two elements. I think clearly limited networks provide an opportunity in order to think through the continuum of care that's available to an individual to try to potentially produce fragmentation in transit.

Several issues are pretty critical. One is what's the comprehensiveness of what necessary services are necessary and available. If they are, how is it they're paid for if fragments of services are not part of the network's overall activities?

So if we need to maintain the ability to deliver various kinds of things that are expensive or other things that are very, very attractive to adverse populations that are very, very sick, how do we not create that imbalance in terms of the network?

COMMISSIONER MORALES: I'm sorry, you mean in terms of product design?

SPEAKER GOTTLIEB: Clearly, not everybody has ever -- it's one step closer to what's in an accountable care organization to have those services. If there are parts that exist in a limited network because those are available and those are being subsidized at the moment by other kinds of payments, they would either go away, the market would shun them the way that they have those services in the past, like substance abuse services which adversely virtually disappeared or rehabilitation and in-home services which are very difficult to maintain with the overall cost shifting.

Or on the other hand, obviously sick

populations will have an affinity to very, very complex services and may be hard to be paid for. Payers then also will try to create barriers. The other is with networks and with any of these products, what's our ability and willingness to limit influx and eflux of patient populations?

Any kind of network or overall program is great when there's durability associated with it. So the network, the payer and the purchaser can work with the providers to work on primary, secondary and tertiary prevention, that will mitigate most expensive utilization.

When people can leave products on a weekly basis, on a monthly basis or even on a yearly basis, I mean, we hold up Kieser. But Kieser has the largest permanence of its populations in California. People stay for years and years and years.

So they can create value in statin care and keeping people on expensive statins for longer periods of time where the trend is in and out that we have right now essentially our accomplishment is focused purely on cost in a very, very narrow way.

So we can put the pressure on access which will then cause downward pressure on cost because we have excess capacity of services. People will shun ultimately complex patient populations. So the design is reasonably critical here.

SPEAKER MITCHELL: Since he was looking at me --

SPEAKER GOTTLIEB: No, no, no. I was looking at you for empathy because I see your tone.

SPEAKER MITCHELL: Just one comment. The benefit's identical. We are not cutting, we are not -- it is not limited benefits. It is limiting choice of providers. That makes a huge difference.

SPEAKER GOTTLIEB: Absolutely. If you look across those providers and some providers because of the nature of the way that services have been established have a broader array of services limited and excluded from their network, there won't be payment to be able to support those.

We've seen that everywhere where

everybody's had to limit stuff, and we've skewed an interest where more expensive higher tech services have paid more.

COMMISSIONER MORALES: One more follow-up. Is it possible, Dr. De la Torre, to do that in Boston, or for anyone else to do that in Boston given the type of unique health care system we have here specifically in Massachusetts?

SPEAKER MITCHELL: No, and to be fair, I have certain advantages that other purchasers don't have. One of the other things you do, and the lady sitting to my left can testify to this because she probably has some scars, is that I beat up on prospective providers to participate at a rate that we can both agree works for her or works for me.

And I didn't get what I wanted, and she didn't give as little as she wanted. But that's, you know, as I say because I'm a big purchaser, there's no question but that I have a little bit of something. It's not because I'm so tough. It's because I'm so big. It makes a little bit of a difference.

MODERATOR WEIL: So any solution is going to be complex, and we're not going to work through all the details here. I think one of the tests for a successful short-term strategy is that it has to be simple enough that the complexities can be worked through fast enough that people can see something.

And so what I'm hearing on the tiering option is, yes, there are definitely some issues to work through. But on the hierarchy of hard to simple and long-term to short-term, it's kind of in the right quadrant as a place to put some effort.

But following on Commissioner Morales' little side comment as he began his question, what other -- that was put out as a market-based approach that could make some movement on price. Are there other things like that that you all want to put on the table, again, other than sort of a regulatory approach that would freeze or potentially recalibrate prices in the market? Yes.

SPEAKER ZANE: So I'm going to waiver back to my Mass. Hospital Association hat for a minute because as an association, we've chatted about this. What can we do tomorrow kind of orientation. And since small business premiums are so much in front of our minds, one of the thoughts that we've been discussing is a large reinsurance pool, not dissimilar from what Blue Cross and Blue Shield has actually brought forward, thinking that a reinsurance pool for small employers could be helpful in cutting premiums to the small business community.

COMMISSIONER MORALES: Ellen, how would we fund that reinsurance pool? How would we make that work.

SPEAKER ZANE: Well, that's a detail, David -- now I'm putting back my own hat because I'm going to tell you my own bias. My own bias everyday as health plans go out and seek premiums from employers, inherent in that premium is a risk reserve. Those risk reserves are sitting on the balance sheets of the health plans. That's a fact.

And for those of us that take risk-related products, when the risk gets transferred to us, the health plan then knows their cost, but we don't. But they keep the risk reserve. There are years of compounded effect of risk reserves sitting on their balance sheets. They're collecting them now, and we should have a conversation about that.

MR. O'BRIEN: If I could just follow up. I actually heard two different types of reinsurance from your answer. One might be more along the lines of what Dr. de la Torre talked about which is as risk shifts to providers in the payment structure whether there should be an all provider reinsurance pool of some kind so it's not every tub in its own bottom as far as risk, and maybe you need some opportunities to true up the system by having both -- because of the population being served and the cost of those as far as the payment.

Separate from what I also heard which is a reinsurance pool to effectively moderate the overall costs of insurance rates within the small group market, are there two there?

SPEAKER ZANE: There are two. I cannot speak to a reinsurance pool for all providers because I'm not an actuary. And I don't know what I don't know about the downstream ramification of that. Theoretically, it's interesting. But I'm not sure how that would work. Relative to small business, however, that's the one I was addressing.

MODERATOR WEIL: So presumably in order for that reinsurance pool to achieve the goal you had for it, the rate regulation on the insurance side is going to have to be with sufficiently tough scrutiny to measure what kinds of reserves are necessary. And say because your risk profile has gone down due to this pool, your reserves are going to have to go down, and that has to go back?

SPEAKER ZANE: Correct.

MODERATOR WEIL: Without that, you're just moving money from one pot to another?

SPEAKER ZANE: Correct.

SPEAKER GOTTLIEB: The question is whether, and clearly being a little more cautious about the notion of completely pulling apart the bailing wire and chewing gum which this system has been essentially paying for itself.

A variety of I think shared savings programs would be a terrific set of incentives. And that is it kind of goes to I think what the presentation earlier showed with Professor Altman, and that is trying to within the context of the current rate structure start to move quickly towards more market forces and more qualitative outcomes where essentially savings in certain areas are identified at the beginning of the year in a population.

And that that allows some liquidity in the potential premium so the providers can use that flexibly to do some of the work on the infrastructure side to create a care package, and then savings would be shared. Perhaps the ways in which those savings would be shared might be different, the providers it serves, the population it serves and the quality outcomes achieved with that population.

It's real money. It's putting money on the table. It's saying, look, this is the amount you got to pay last year. If you have a ten percent savings from last year, we'll share it in this way. You'll bear some risk

MODERATOR WEIL: Who would have structured the population for which you are looking?

SPEAKER GOTTLIEB: I think purchasers like Dolores who are in special positions to look at populations who truly understand what the highest risk is and where hopefully the payers can also describe with their data who those people are with highest risk of utilization would be where the most money is for that because that's where the most savings is likely to be.

I think you can step that down even to the broader commercial population. I think this requires a partnership among the payers and providers to be able to look very, very directly where the savings are. That's not something we're able to do before. It does seem the climate is a little more catalytic --

MODERATOR WEIL: Let me try to take that and generalize the comment. If there's a vision down the road of accountable care organizations and bundled payments, from a dollar perspective, the yield is highest on the cusp populations.

If we could in the shorter run segment out a subset of this massive 6 million or however many people we're talking about to those that are driving the largest set of costs and develop some market-oriented incentives for savings and out population, that could potentially move dollars much more quickly than reorganizing an entire delivery system oriented toward the population as a whole.

SPEAKER GOTTLIEB: First, it's the easiest population to get waivers for for some of the barriers would be mitigated because of the earning waivers that exist. Medicaid has much more flexibility in experimentation.

In the state, there are some wonderful Medicaid payers like the one to my right who have the ability to participate in those kinds of partnerships. And frankly, you know, if our overall mission is to take care of the sickest and neediest populations and in this state where we have been gifted in having extraordinary young people come here who are focused on those mission-related issues, we'll have solutions that effect this kind of care relatively rapidly.

MODERATOR WEIL: I want to shift to the next topic. I know the reports put a laser focus on price. I think in research with other payers and from experience with price regulation, we know that volume can very quickly dominate whatever efforts you make with respect to price. And so even as we focus on price, let's talk about the volume side of this.

And again, we're looking now for sort of the quick wins because there's this hope and optimism that longer term system reorientation can bring together price and volume in a way that yields positive results. So my question would be, Are there changes in benefit design that can relatively quickly address some of the volume driven increases in overall costs?

I share Dolores Mitchell's version to the term skin in the game. I always like it when someone calls that rather obnoxious phrase out. So I will endorse it. Other than simply shifting costs in a way that we think will drive down utilization irrespective of its value, what can we do in a benefit, in the area of benefit design or other steps that would address some of this volume driven price increase or volume driven cost increase?

SPEAKER ENOS: Well, I'm not going to comment on the benefit design. In terms of another area, and to pick up on something that Gary was talking about, he used the term partnership a couple of times. And these hearings are rightfully focused on cost.

But I think it's important to recognize, and I feel personally that the real sort of opportunity here is in this partnership. Cost is clearly an issue that we need to tackle. But in collaborations we have, and we have them with many people at this table, the cost is not the only thing that we're collaborating on.

So it's a more of a comprehensive approach of looking at the cost of services to our members, but also collaborating on clinical programs, patient outreach, et cetera. So I think that's an important sort of comment.

With respect to sort of utilization in that concept of partnership, I think one of the critical things, and health plans do this now, but I think we can do more of it and do it in a way that is more readily available for providers is the shared power of information.

Often times we find that providers may just not know what services their sort of patients are getting. They know what they are providing themselves. Depending on the system and the sort of whether or not there's electronic records, et cetera, they may have that information.

But often, they really don't know what's happening outside of their walls. So one of the most critical things is, and health plans can do this, is to derive that information as quickly as possible back to the providers. And often enough, it's a matter of just realizing what is happening with respect to their members, if they're accessing specialists that the provider, primary care doctor may not have known about, what what's happening with their prescriptions, et cetera.

That one thing of bringing that information back in a very quick way to the providers and in a setting that that can be shared, you know, I have seen that in and of itself has made a difference.

MODERATOR WEIL: What does it take to make more of that happen?

SPEAKER ENOS: Well, I think there is, as had been said before, in some cases there are investments in terms of the technology to be able to share that information. Actually, there is a fair amount of that now. I think it's more not even the technology as much as it is, What do you do with the data?

It's one of the things we've learned just shooting data out to providers is not necessarily the answer. It's a matter of having the data, having it readily available, but then also having a forum to sit down and discuss it, to show them benchmarks with respect to their peers.

It's really what is the construct in which the data is reviewed. I think you can set up mutual goals that work both for the members, for the providers, for the health plan in those settings. But you need a contract. We have a lot of data all over the place. It's how you bring it together and use it in a collaborative way. It does include an investment of time. It's really resources, professional resources on both sides that invest the time to do that together

MODERATOR WEIL: If I were to expand my question about volume to also include provider mix as another source of cost pressure, I'm going to ask Dr. Lopez, you have this large multispecialty system. How in that system do you try to keep an eye on and what again policies can support your assurance that when or making pressure on price it just doesn't just come out on the volume side?

SPEAKER LOPEZ: Well, you know, I think we have a large network of primary care and specialty providers. And so that, all of whom are sort of oriented towards the same goal in terms of our organization and are tied together with the common electronic medical record.

I think that is, and it still gets back to the IT thing that is really critical. Because we all can see what we each are doing, and it allows coordination of care in a way that when I have patients whom I'm only seeing as a primary provider and they're getting their specialty care elsewhere, it's just not possible.

So you know, certainly organized around a common electronic medical record allows for that kind of coordination. Another point here is that coordination is only possible around the selection of a PCP. And that's, so it gets back to the choice issue. But it's a reality. And a patient who has selected a PCP, that PCP is, has more access to information than in an otherwise sort of unimagined product.

A typical example, my patient gets admitted to the hospital. The hospitals knows who the PCP is. So they send me information. A PPO patient or Medicare patient, straight Medicare, I get no information because there's no particular reason. The hospital isn't mandated. They don't necessarily know. So selecting a PCP is also critical.

MODERATOR WEIL: So I feel like these are tools, but not necessarily the push. And maybe we don't need a push. But I'm interested in some of the push side as well.

SPEAKER DE LA TORRE: I just want to caution, and everyone sees where I stand especially on increase in health care costs. But we always have to be careful of the law of unintended consequences.

One of the realities in a

fee-for-service environment, hospitals, especially community hospitals are priced on the margin. What do I mean by that? It's that last X amount of delivery is the entire margin, the entire profit lien of a small community hospital and are already down around 1 percent.

So if you set up a strict, a structure where, remember, we have competing interests in communities. We have physician groups that own a lot of imaging, that do a lot of outpatient surgery. We have other centers that do their own imaging that compete with the hospital.

What happens is if you drive utilization, you're going to bankrupt community hospitals because, you know, you're literally stripping their margin because the inpatient care doesn't really make a heck of a lot of money. And the outpatient setting has already been stripped by a lot of these other providers.

So we have to be careful that in a fee-for-service, in a pure fee-for-service environment, without a payment reform, if you do something like that and really drive down utilization, be prepared for a bigger commission desk type of consolidation. That is a different issue for a different day; but we just, you make sure we understand that.

SPEAKER GOTTLIEB: The payment incentives are critical in order to be able to ease the over utilization which particularly the report showed us so eloquently were focused on very large increments on the ambulatory side.

Not only were we encouraged for years, but the incentives have driven the use of mostly technology on the ambulatory side. The rapid dissemination of that technology and without moving pretty quickly to some subset of bundled payments that look specifically at disorders, we'll have people who are driven by pretty low specificity tests that are very low sensitivity associated with them in order to respond and are also responding to a set of incentives.

The other element, and I don't know what its overall value is, but those who are fearful of some kind of litigation seem to use those resources extensive. And I would say that you know that's probably an overvalued component.

However, there is something that I think the Division of Insurance could do that could be helpful to us in that regard. The more that data can be shared as to how one reduces overall liability, the more that that can be used as learning and teaching to improve behavior and quality I think would be remarkable.

We have the great fortune of being part of a captive that relates to the Harvard teaching hospitals and has basically very, very transparent data and has created with it a set curriculum that focuses on specific high risk for physicians and also looked at a variety of other components.

If we believe that ordering behavior in terms of over utilization of high cost imaging is driven by fear of litigation, all we would need to do is truly inform ourselves based upon the data, try to look at operational components from which we work together and sharing those data across the system.

Most of the commercial carriers I know are pretty opaque in terms of sharing those data with the groups. So it could be an opportunity to just throw that tort issue aside and allow us to really work again with information sharing.

MODERATOR WEIL: I'm struck by a chicken and egg problem that maybe was obvious to everyone else, and just I'm slow to come to it. On the utilization side with the margins that Dr. de la Torre you mentioned, without payment reform, efforts to drive down utilization are going to drive institutions out of business. And they will complain before they let that happen.

But in order to do payment reform, you need a different delivery system to receive those payments to do the right thing with it, and the capacity of the system to do the right thing with those payments is limited. And it seems to be particularly limited to those places that are most fragile with respect to utilization.

So where do we start in trying to address the utilization component of this simultaneously with payment reform without just making the system collapse?

SPEAKER DE LE TORRE: Non-hospital-based utilization.

MODERATOR WEIL: Say more.

SPEAKER DE LA TORRE: You know, we were

just talking about on the margin of hospitals that if you strip them of a lot of their outpatient procedures like imaging and surgery that you're going to drive them into bankruptcy, there's no doubt, without late payment reform already in place.

Yet, there are a lot of providers that are not hospitals that are either large groups or imaging groups or surgicenters, et cetera that take out the high profitability procedures, testing, et cetera from the hospitals.

And I think there is a realm of utilization that does not necessarily contribute to the overall margin of healthiness of hospitals or ACO's per se that we need to identify and deal with.

MODERATOR WEIL: So obviously, they're not going to be any happier taking it out than anything else, so the risks to the citizens of that lost revenue are smaller?

SPEAKER DE LA TORRE: Well, if you go with the fundamental assumption that we need to decrease utilization, let's start with everybody agrees with that, then what follows if you look at the margins that community hospitals generate and you ask any community hospital CEO or CFO, if you take 5 percent of your imaging or 10 percent of our outpatient procedures, what's going to happen to your bottom line?

They're all going to answer the same way. We're going to cease to exist. We're going to have to accept a certain amount of hospital closures with redistribution of volume, or we have to prevent the decrease of those volumes while decreasing out utilization in these community hospitals.

Again, that's a much bigger decision. That's really what it comes down to.

SPEAKER ZANE: I really believe that all roads lead back to fixing the basic inequities in the market. Yesterday, I believe Dianne Anderson at Lawrence General Hospital spoke about how it's impossible to sustain a community hospital when they're being starved.

When you think about how we're going to preserve the high quality, low cost community hospitals, all roads lead back to the same issue. We can't dance around that. We have to fix it.

COMMISSIONER MORALES: So Ellen, how -- can you share some ideas as to how you would effected by that.

SPEAKER ZANE: When I go back to the concept of a fix, I think where state government can have a role, and I'm not going to assume what exactly that role is, David, we have to be able to somehow say that the gap that currently exists between the higher reimbursed and the lower reimbursed has to not exceed X, whatever that is, so that the Lawrence General Hospitals of the world can reinvest in themselves so that the problems that Ralph articulates don't keep them so marginalized.

SPEAKER GOTTLIEB: The one problem only in that area is that those hospitals find themselves in communities that were different than when they structured themselves. If in fact those inequities are fixed, they may find themselves with different payer mixes. It becomes a challenge.

SPEAKER ZANE: As I said earlier, all payers have to participate. So this clearly, we're cost shifting. Some of us we're able to cost shift to the commercials better than others. But my comment in my testimony about government stands.

MODERATOR WEIL: So I want to try to pull this in to the next level which is we had a discussion about the price and volume market approaches, limited ideas, but very good ones. Then there's tendency to ask sort of what the regulation can do.

I am confident in the time remaining we could not work out the details of a regulatory structure. So we're not going to try that. But maybe we can talk about a kind of infrastructure issue, the state-based necessary to create the kind of policies that you all have discussed as the types of regulation that might be necessary to ask the question is it possible to think of regulation as a short-term solution?

After all, if everything you're going to regulate you're going to spend five years figuring out what the right number is, then it's not a short-term solution. So the question is, Do you have an infrastructure, and can you quickly create an infrastructure that is going to be credible and that you all are willing to rely upon to make these important decisions about allocations of when we think about when we went through a planning, when the nation relied on health planning, we had the federal government supporting a major infrastructure. You all used to have that infrastructure. It's largely been dismantled.

So is there, is there enough of a starting point, a sense of confidence in the capabilities and the capacity of the government to take you down this road of trying to rationalize and use a regulatory structure to overcome some of the disparities that have been demonstrated in the data reported over the last few days?

SPEAKER MITCHELL: The answer is out there, not up here.

MODERATOR WEIL: What do you mean by that?

SPEAKER MITCHELL: Well, I mean, you've got legislative action that has to take place. You have the leadership of the Governor that has to take place. You have the agency heads that have to work with the Governor's office.

You have the Attorney General's Office that has power to do certain things. And we do have the insurance commissioner sitting up here. There are some things he could do, I suppose. But by and large, there are more of the decision-makers out there than are on this side.

MODERATOR WEIL: So then let me follow it up in a slightly different way which is that without the confidence of those of you up here in the ability of those out there to adopt a process that will be credible, the likely result of regulation is nothing in the way of improvement.

We know that regulation in and of itself does not yield lower costs. It's only regulation in the context of willingness to use that as a force for change.

So I understand that you aren't the decision-makers, necessarily, on the panel. But your willingness to sit here or stand and say that given the limitations of the other approaches we will endorse a process like that, that's a strong statement. And I want to know if any of you are willing to make it?

SPEAKER MITCHELL: But I don't agree with your assumption that regulation doesn't work.

MODERATOR WEIL: I don't think I said that. I said that regulation if it's not, if it doesn't have any political force behind it --

SPEAKER MITCHELL: Oh, okay.

MODERATOR WEIL: -- then it has no effect.

SPEAKER MITCHELL: Sorry.

SPEAKER ZANE: So what's giving me pause is that I reflect -- I'm old enough to remember when there really was a pretty strong DON process in Massachusetts. And I reflect on how it was politicized and how providers that didn't like the DON process would submit legislation to get around it.

So I think the credibility of such an enterprise that government might help promulgate has to be associated with credible individuals who are knowledgeable individuals, maybe not from Massachusetts perhaps, in order to sit over this and give thoughtful, rational, reasonable expertise and not have a seat on such a panel because it's politically correct.

That's when it loses its credibility, when the folks that occupy the seats are not really knowledgeable, when they have no on the ground, in the trenches experience of managing anything and when it's politicized.

MODERATOR WEIL: So that's a helpful start to a conversation. And I want to ask for more along these lines of what it's going to take to accept the outcome of a process like this.

SPEAKER DE LA TORRE: I think that, talking about the politics of it, Ellen, a fundamental problem that every solution that makes sense that we've all talked about, whether there's limited network, payment reform that limits utilization, all those things, the populace doesn't like it.

Right now the people that live in Massachusetts don't fundamentally like that. They don't like it, most of us will argue, because they don't understand exactly what that means. But when you put the politicians in charge, and I'm not speaking bad about politicians. I actually have some as friends. You know, they have to get reelected.

And it's very tough to sit there and say, you know, I'm sorry. There is no solution that gives everybody in Massachusetts a no copay, no deductible system with infinite flexibility and everything you ever wanted. You can't have it.

I think that's what would be my line of stance. If we get a group of politicians that say, you know what, we're going to do this no matter what it takes. If we never get reelected, so be it. We're going to do that. We're going to make it our mission. Then you would see a lot of us jumping on the bandwagon to support them, to do whatever we could to do that.

If it's going to be before the easy fix and making the headlines and sound bytes, then we're not going to get out in front of them.

COMMISSIONER MORALES: So let me just jump off that point. So we set the table for a conversation. They're in the audience. I guess the onus is on you to say here are the short-term solutions or ideas for you to take up or for us to put in our final report. So if this isn't the space, then what is the space? If this is the space, then we'd love to hear it.

MODERATOR WEIL: Wait. The recorder will object. Please.

SPEAKER GOTTLIEB: It's different than the question that you asked. And the question is, How do you create a trusting process where some don't get vilified or isolated, where the process is not about threat but an understanding that there's going to be sacrifice all over the system in one way or the other because it's going to have to be re-molded in a certain direction and creates some set of transactional trust to be able to get to that point. That's a hard thing to do.

It's a hard thing to do in an environment where you have those kind of charts and where there are ups and downs in the system and where care is sporadic and where essentially you have a market that's evolved over a period of time for a variety of different reasons without thoughtful policy.

The state took a step to put forward policy around the social elements of justice. I think the world should applaud that as the President of the United States is trying to do.

That is without saying. Now the question is collectively, how do we hold on to the preciousness of that, protect it in a way that's consistent with the extraordinary value that exists here.

Don't throw the baby out with the bath water and still be a leader in technology and academics and other components while not essentially bankrupting extraordinary small institutions who would be frail in that regard. That's a real lot of compromise. And there's going to be a trade-off in that regard.

I know each of us has simple solutions around that. In order to entrust a source to be the authority, to be the truth which is what the government ends up being in this circumstance, we have to figure out what the parameters are of a real workable partnership and to some extent understand that the expedience of a solution that comes before election day or a certain time is much harder to get. It's really harder to get.

There's so much good, which I think Dr. Altman was saying to us, and there's so much problem which is what Dolores has described to us and what the marketplace tells us that to think about a thoughtful kind of outcome is really going to take a lot of work and a substantial amount of trust.

So to just say we're going to empanel this group or to say we're going to use the authorities invested in me by law to come up with an outcome is not going to have that form of partnership. I apologize for not knowing the size or the shape of the panel. Even Stuart Altman couldn't come up with one that exactly works.

Certainly, the I-cap that's in the current bill that the federal government has isn't one that all of us thought about anyway. I think in sympathy to Ellen, I think what the President tried to do is consider having the general accounting office be the appointer. So I think you have to be very, very careful. But I think it's critical to do it, to try to put on the table now how we're going to create this trust.

MODERATOR WEIL: I want to follow on that. I really appreciate the way you put that.

Part of why I raise this question is if there's a sense that we're in crisis and we need to move fast and regulation is viewed by many as a blunt but maybe necessary instrument, I want to pose the question of whether we can move quickly with regulation or whether all of these trust issues that you described needing to work out are going to take too long for us to yield results.

But I also do want to hear concretely, not just sort of we will embrace regulation if we like the process, but what that needs to look like so that the process if that's the path that the Commonwealth is going to take will begin.

SPEAKER MITCHELL: I don't know. Machiavelli said, what, 600 years ago or so that when you have a system which by and large works for most people, they will fight to the death to keep it from being changed. Whereas those who might benefit from a change are not organized enough to demand that change and fight with significantly less passion because I don't know that they would get a better deal if they accepted change.

We're certainly seeing that in

Washington. I mean, that's exactly what's happened over the past six months. We're going to get something on Sunday I understand from this morning's paper. Not what some of us wanted. But you know, you look at the history of social change in this country, you see that it has only come when the middle class, itself, gets effected.

And we thought we had that in the current situation. And yet, it still didn't work. I think partly because of the animosity and anger that's out there and the fact that when you're talking about health care, you know, that hits at home much more emotional than almost any other social program can be.

So I think it's a very large hurdle to meet, but I would hope that the political leadership -- and unfortunately, we're also in an election year. Let's face it. That makes life much more complicated. So I cannot see after the election in the fall, however it turns out, that we can get the senior leadership of the Governor's office, the Attorney General's Office, the regulatory folks who are sitting over there and out there together to push together for it; but otherwise, I think it's going to be very hard.

I don't think just bringing in something like a base closing commission is going to do the trick. You know, and data won't do the trick either. You can show that some of the hospitals whose potential closing is most passionately opposed by the neighbors, and then you look at where the neighbors actually went to get their care. And none of them use those facilities. So closing a neighborhood school, it may be a lousy school, but it's our school.

MODERATOR WEIL: I think we're moving a little bit too much into distraction. So I want to ask a final, I want to ask a final question which is regardless of the exact techniques, I'd like you to offer some guidance to leadership in this room.

We again are here and motivated by the sense with lots of data supported among the citizens of the Commonwealth that cost is a problem. And there's been terrific analysis to show what's driving it. Where in that big puzzle is it?

Is it at the hospital level? Is it at the system level? Is it at the insurer level? Where do you suggest, regardless of the technique that the focus be placed on, within the system to yield quick and not harmful to the public changes that will help address this cost problem?

Where do you think the focus ought to go first if we're trying to do something to address what the, what the public views as a crisis? I'll let you start.

SPEAKER ZANE: In fairness, I think we've answered that question.

MODERATOR WEIL: I know you have. But I'm not sure everyone --

SPEAKER ZANE: All of us have talked about our ideas, whether it's limited networks or chronic disease management or whatever. I think we've said where we would begin to go down that path. Where I'm bringing is the constant drum beat of where are we going to get a quick fix because I believe that's naive.

There are so many moving parts to all of this. And to say we can chop something and not have a downstream effect I think is dangerous. We need to be careful irrespective of which part --

SPEAKER DE LA TORRE: In order to do what we're going to do tomorrow, where we're going to head home, we need an understanding of where we're going to be in three years or five years. Then we can embark on the dream. Then we can ask the question, What can we do immediately that doesn't hurt our plan for three to five years?

MODERATOR WEIL: I think that's certainly appropriate. And as I think about the principles for effective short-term change, clearly one of them is to be consistent with your long-term vision. But I worry that as I believe, as Deb Enos said at the outset, you're eight months into your five years, and you're not there yet.

And it's going to take awhile to agree on this vision with that level of specificity. If the notion is we can only do short-term after we've defined long-term, then short-term is already gone.

So with total respect to the maybe naiveté and maybe unrealistic notion that you can move this system in ways that aren't harmful, that's what people are asking that we try to do. So I think it's unrealistic to just say the answer is that there's nothing that can be done in the short-term until --

SPEAKER ZANE: I think it's really unfair to say that we said there's nothing. We have not said there's nothing.

SPEAKER DE LA TORRE: Yes.

SPEAKER ENOS: To echo something I said and I think to echo what Ralph said, we have to start the plan. We're eight months in. We'll never get there if we don't start. That's a real thing. Whoever is supposed to own that needs to start that process and get a plan.

No. 2, we've mentioned limited network several times. I look over at Commissioner Murphy, change I would recommend, at least look and consider changing your policies concerning how to designate a service area. The requirements of which providers need to be in right now, they're restrictive. They do not facilitate limited networks.

You require that too many providers need to be in and relax the ability of plans to differentiate through copayment so there's an incentive for consumers to opt into the more select network.

Third, with respect to more publicly-funded programs, we need a strategy of how to work within extremely limited resources to maximize efficient uses of delivery systems and providers. And that is under their control.

We don't need additional regulation. 85 percent of my business is under that control, and every single day I beg for that. Hopefully that's specific.

SPEAKER MITCHELL: And we have a five-year recommendation. It's called a payment reform commission recommendations, and it was a unanimous vote I might add. And that's sort of what I meant when I said the answer is largely out there.

I represent Ms. Stanley who's smiling because she knows I'm about to throw a hot potato in her lap, that they need to get started on it. Deb is absolutely right, and she was right when she started an hour ago.

SPEAKER GOTTLIEB: Well, the biggest piece of crisis is the burden on government because the government is the most painful, is a part of the system that is in the most pain at the moment and where our leaders are going to have the most difficult choices among things that are all precious to us.

I think the latter component of what you described, Deb, that is focused specifically on very, very high users and that sub-population where you can scale up existing programs rapidly, hold us accountable to scale them up, that's going to change things. It's going to cost us because we're going to end up with over utilized capital.

SPEAKER DE LA TORRE: I want to disagree. I think the biggest problem we're facing is not the impact on government. Government has never pulled this country out of deep recession. Small business have pulled the country out of deep recession. So we need to figure a way to help the small businesses in our community right now.

SPEAKER GOTTLIEB: But they're subsidizing what government can't pay anymore.

SPEAKER DE LA TORRE: In that case, we're all intertwined. But it's really, the impact on small businesses are getting crushed. And that's what some of the limited networks potentially, we talked about -- if you go through the transcript, there were a series of ideas that you can do immediately.

What I'm saying and what Helen has said and what others have said, as you do these, you have to keep in mind the results of the payment reform commission and where we're headed and ask yourselves, as I put this policy in place, does it give me a quick fix but move me away from that goal, or does it move me towards that goal?

MR. O'BRIEN: First, I want to thank the panel and the moderator for the lively discussion. I know we're finishing up soon. I know there are been some good ideas and have been indicated well.

I want to get to the idea that Dr. de la Torre has. There needs to be a cultural shift with consumers and how they interact with health care. I think this shows in Dr. de la Torre's comment whether there also needs to be a cultural shift in the providers' side.

To the extent that outside, there's a lot of topics. There's a lot of arms race going on. There's a lot of advertising. There's a lot of business. I understand that, you know, we recognize that it is a business. It's big business.

But whether it's a chewing gum kind of luxury tax that you mentioned, are there some things that are existing with payment reform over time that the provider community can take on to kind of change some of the culture of competition that makes it positive rather than what someone might perceive as driving just larger footprints to certain entities?

SPEAKER DE LA TORRE: It does potentially cap on the top end profitability and takes some of those and drives it into fund government programs to help with other things. And yet, what it does is it's going to incentivize people. We're all businesses. We're going to find ways to make profit.

So if you create the avenue to profit as an incentive to creating, to accept payment reform, then by kind of minimizing the high end impact of fee-for-services, you accomplish two goals. You get a short-term fix while heading in the right direction.

SPEAKER GOTTLIEB: Certain payment reform will reduce any arms race. Once you reduce bundled payments or global payments or in some kind of shared savings as described very early, then essentially capitalization has very minimum value unless it substitutes for something that's otherwise more expensive.

That's working capital around practice models that may be more efficient or effective or substitution of more expensive stuff. So driving in that direction along the very streams I think we've described here and by the Payment Reform Commission have value in change of what you're describing.

Obviously, it will create more anxiety. Anxiety creates more competition. Hopefully the competition will be around being qualitative and showing value per unit of service. And with trying to emerge with measures that can differentiate providers, I think one of the issues, I think you did a great job for trying to use all of the available quality measures. That having been in health quality services for much of my life and policy, we know what information is available to us, and we can't differentiate well in the key areas or key provider.

They're going to have to be very disease specific, treatment specific and where the highest costs are so you can measure cost per unit of value in the very high dominated areas. I think we have to move this stream of gradual payment reform in order to make changes.

MODERATOR WEIL: So if I may, I was asked to make a few summary comments at the end. I will begin those now. I think it's great that you have someone not from Massachusetts moderating so that as the anger on the panel grew when I get on an airplane, it will all be gone.

But a few observations are from my experience both with my years at work with the Commonwealth but also other states, the first is don't undervalue the consistent, the consistent support you have for the long-term vision created by the Payment Reform Commission. That is a tremendous asset. And although clearly there is work to be done to give that vision meaning, it is such a bold statement heard around the country. And it is a platform from which you can work.

Second, if you're thinking about the importance, and I'm sorry, I did focus so much on short-term cost control because of the sense of crisis, it does seem that there are a few principles to guide whatever you do in the short run. The first is that it needs to be incremental. You can't -- you're going to have too much opposition if you change anything too much too fast. Then it just won't happen.

Second, it needs to be reasonably simple because you can't do complex things too fast. And third, it needs to be consistent with your long-term vision. If you do things in the short run that make it harder for where you want to go, that makes it bad for a lot of different reasons; and it also won't work.

The third observation I will make, I think there's a very compelling case to be made that the investment in transforming your delivery system into one that can operate in a capitated bundled payment model, it's a social good. And we have models available to us to think about how to fund social goods.

You could, for example, have a fund, a state-administered fund with competitive grants to organizations that made the case that they need the resources to do this. Part of the way they make the case that they need the resources is by pointing to this chart and saying those resources haven't been built into our rates.

If you think about the movement around the country towards building patient center medical homes, there are state-based infrastructures being developed around the country to support individual practice change. I'm not trying to suggest these two are the only models.

But once you realize that that investment is necessary to achieve your long-term vision, you can treat it as a good that should be funded and supported and designed through a separate stream and not just built into your pricing which is still, despite all of this information, rather opaque. And that gives the opportunities to do things you wouldn't have otherwise been able to do.

Fourth, I think it is important as you think about the challenges you have in shifting your delivery system that you do keep an eye on the actuarial yield of the relatively small portion of the population that drives the largest share of the costs and who, frankly, in many respects gets some of the worst and uncoordinated care.

It is good for people and good for costs and frankly less descriptive to the whole delivery system to focus on a subset. If you're going to focus on a subset, don't focus on the cheap commercially insured folks whose services are provided throughout the health care system.

But focus on a higher cost population where, again, we know the need for improvement. And frankly, your leverage for change are more internal because it's more Medicaid than ERISA or Medicare or other sources that might be challenging.

I've lost count, so I think I'm at five, which is I was struck by and intrigued by the great interest in tiering and limited networks. I think that's a ball to run with. And again, I don't know that I got quite the answer I would want for whether this is about pedagogy, just showing people what they're paying for; or if you can really tier on quality; or if it's just about price. But it almost doesn't matter.

This is a direction that there's enough interest in and there's some identified barriers that it's worth trying to figure out how to get over those barriers.

Next is I do have to say that some serious effort is going to have to go into the next layer of analysis which is disentangling the cross-subsidies. Everyone can make a case for why their costs are higher than average. Everyone has a story for what they do that other people don't do.

When we worked on the blueprint for coverage trying to figure out where those DSH dollars were coming from and where they were going was not an easy thing. This an order of magnitude more complex. If you're going to have political support and consumer support and public support for any kind of movement, you're going to have to drill down into those cross-subsidies so that you're not just looking at one payer at a time. You're not just looking at a consistent set of services.

You're taking seriously the arguments of why people are making arguments of why their costs are outliers and then creating evidence based on that discussion so everybody isn't, of course, well, I'm different.

My next comment harkens back to Professor Altman's comments about his sort of three-tiered approach. If you're serious about cost containment in the short run, it's hard to imagine doing it without some sort of aggregate cap on spending.

I think his notion that you need to treat how you apply that cap in different care delivery settings and financing settings is a very good way to start. I'm not saying do it. I'm saying if you want to do it, you need to think of it that way.

Even if the rate of growth is the same across settings, how you apply that rate of growth is going to differ. I wasn't here when Steve Schoenbaum spoke yesterday morning, but I'm a member of the Commonwealth Commission on a high performance health system. Part of our work has been building a chart that I think is helpful that notes that different levels of aggregation create different opportunities for global payments and bundling all the way up to full capitation.

You have a system of variable structure and variable payments behind that structure. So if you're going to anything that looks like a cap, you do have to apply it differently. And I think that insight in his proposal is critical.

And finally, and yes, this is the last one, I do have to say I've been struck over the last couple of days, and I mean to pick no fights in my final comment, by the number of references to the people and they want everything and they don't want to pay for it and this and that.

I have to say I find although I know that that's never the whole feeling that's being expressed, I find that very destructive. It's as destructive from my perspective as talking about skin in the game.

As a non-clinician who's just periodically a patient, I have to say the overwhelming majority of what I do is because my doctor says I should do it. And I need guidance from -- I know that I need guidance from other people to make good decisions.

And so although I think the endpoint of a lot of the discussions about people being disconnected I would agree with, we need to integrate and engage. We need to integrate and engage people with the respect that's due to them about their capability of engaging.

Sometimes I fear that the language that we use to say that they don't get it is not a real inviting way to bring people in to participating in their care and to participating in the cost problems that we confront.

So I will just say as an outsider, I am impressed by the level of analysis done by you all and your staff and the commitment of the panel, the level of thought in the state that you have demonstrated once again your leadership on these issues.

I can only wish you good luck in taking the next steps; but please those of you in the audience, join me in thanking the panel for their contribution.

COMMISSIONER MORALES: Thank you so much, also to Alan for his work as moderator. Round of applause. Thanks again to this panel for its open, pointed and robust discussion. I appreciate it.

A couple of more things. Before we break, I want to thank again the panel for an open, pointed and robust discussion. It was very, very helpful. Second thing before we break, also I want to acknowledge some folks I didn't get to acknowledge here earlier who are here now, Commissioner Joe Murphy, Secretary Barbara Anthony, thank you for being here, as well as Representative Mary Grant who is here also.

When we come back at one o'clock sharp, we will hear from some public testimony. Lastly, we will also hear from Assistant Attorney General Tom O'Brien who will examine a couple of individuals from Tufts Medical Center and Paul

Everett from Beth Israel, I believe, as provided by Chapter 305 of the Acts of 2008. Thank you. See you all at one.

(Whereupon, the proceedings suspended at 12:30 p.m.)

C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS
ESSEX, SS.

I, Christine L. Warwick, a Notary Public and Certified Shorthand Reporter duly commissioned and qualified in and for the Commonwealth of Massachusetts, do hereby certify that the preceding transcript is a true and accurate transcription of my stenographic notes taken in the foregoing matter taken to the best of my skill and ability.

IN WITNESS WHEREOF, I have hereunto set my hand and Notarial Seal this ninth day of April, 2010.

____
CHRISTINE L. WARWICK
Notary Public
Certified Shorthand Reporter

My Commission Expires:
May 14, 2010

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Massachusetts Health Care Cost Trends Final Report

Appendix C.5f

Health Care Cost Trends Public Hearings

Transcript for Afternoon Session Friday, March 19, 2010

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COMMONWEALTH OF MASSACHUSETTS
DIVISION OF HEALTH CARE FINANCE AND POLICY

ANNUAL PUBLIC HEARING UNDER
M.G.L. CHAPTER 118G, Section 6.5
HEALTH CARE PROVIDER AND PAYER
COSTS AND COST TRENDS

PANEL:

David Morales, Commissioner, Department of Health Care Finance and Policy
Louis Johnson, Office of the Attorney General

HELD AT:

University Club, 11th Floor
Joseph P. Healey Library
University of Massachusetts, Boston
100 Morrissey Boulevard
Boston, Massachusetts 02125
On Friday, March 19, 2010

Afternoon Session Commencing at 1:00 p.m.

COPLEY COURT REPORTING
The Mercantile Building
78 Commercial Street, Suite 700
Boston, Massachusetts 02109
(617) 423-5841

P R O C E E D I N G S

MR. MORALES: I do acknowledge and invite to the podium, Inspector General Greg Sullivan.

MR. SULLIVAN: Thank you very much, Commissioner Morales.

For the record, I am Greg Sullivan, State Inspector General, and I thank you very much for the opportunity to present some testimony here today. This great initiative that you've undertaken. I'd like too make a recommendation, which I want to present you today and I think that it's indirectly, but also in many ways highly related to what you're doing.

First, though, let me acknowledge the work that you're doing with respect to commercial payers and the affordability of insurance in the private marketplace for individuals, families and groups and business people in Massachusetts. Since the health reform act passed, premiums have gone up between 40 and 50 percent.

I saw in the comments yesterday of Congressman Steve Lynch, in his objection to the healthcare plan in congress, that he felt that the plan does not have adequate control on costs, not enough pressure on costs. That is a theme that the Inspector General's office has been trying to tout around Massachusetts about our plan.

This process that you've undertaken as a result of the legislative reforms and Senate President Murray and all the other others who initiated this process, you're looking to find a way to put that pressure on, and that is very commendable to be able to do that.

My brother is a small businessman. He's a one-person businessman and his family plan for health insurance is $21,000. And as he pointed out to me, that represents $10 an hour that he pays based on a 40-hour workweek for health insurance after tax, and that's a lot of money. So we've got to do something to effect the commercial rates.

I have a proposal that I'm trying to put forward here today, and I want to continue to work with you on this after this meeting, and it has to do with the subsidization of private health insurance rates because of public payers, public purchasers of health, Medicaid, Commonwealth Care. These -- this has been a constant theme in Massachusetts over the last decade that the rates of commercial insurance are driven up because the hospitals and providers are effectively subsidizing the rate of public payers, Medicaid and now the connective products, Commonwealth Care. So I have a suggestion of how to deal with this.

There have been examples of this method I'm going to describe used in other states for a limited -- in a limited way, and I think we should do it in a very substantial way. And that is to use competitive procurement in

Massachusetts to purchase medical services, inpatient, outpatient, laboratory, durable medical equipment, to -- and to undertake a process whereby we would use a procurement methodology to purchase those services for Medicaid both in the MCO portion and the fee-for-service portion and for the connective products. That we would require procurement of health care.

I think that this would save hundreds of millions of dollars a year. I think we could save $100 million this year at a minimum.

In order to do this, to use this method, we have to get a -- we would have to get a waiver from the federal government called the "1915 Waiver." These kind of waivers been given out in many states, not exactly for the purpose I'm describing. We already have such a waiver in Massachusetts. We have received a waiver. That's the reason that we were able to have our MCO system in Medicaid.

In the purchase of services in the government, we use a bidding system here in Massachusetts, and you know it really works very, very well. The government is able to get good prices on things because its a big purchaser, and the RG's office is right in the middle of overseeing public purchasing. So every day, every day of the year, we're involved with looking at the procurement of goods and services and the government.

The best way to procure services from a procurement point of view is a two-part process. First part, pre-qualification of the bidders. In this case, it would be, for example, hospitals who wish to provide, for example, ordinary childbirth services.

This would be a carve out in a bid where the end result would be -- or the -- be -- first step would be the Commonwealth would set rigorous standards for quality, and only those facilities who meet those standards for quality would be allowed to bid. But once they meet those standards, the competition is price based. That is the gold standard of success in government bidding. The best way to get a good deal. That is what I'm suggesting we do.

The peculiarities of the way that Massachusetts pays for Medicaid and Commonwealth care represents a handcuff that we put on ourselves that drives our costs up unnecessarily. And the reason that we have that handcuff on is that we put it on ourselves, and there's no reason for it. We have to harness the power of competitive procurement to get a good deal. It works everywhere; it will work here.

I'll give it a practical example. Because of the way Medicaid pays for inpatient stays under the standard payment amount per discharge, it's called "SPAD," every hospital has a payment, a standard payment for anybody who stays at that hospital for either one day, up to 20 days. For example, the SPAD rate for some of the teaching hospitals could be 10,000, 11,000 or even more per day, per -- per admission. So if somebody goes to a teaching hospital to have a baby, the Commonwealth is going to pay $11,000 for that. If they go to Norwood Caritas, they'll pay $4,500 for that.

If -- if this were a competitive procurement situation, the government, and somebody came to me -- to the IG's office and said, "We're purchasing services," and the low cost, qualified bidder is being bypassed and the business is going to the high bidder, we'd call the Attorney General's Office. But it falls in the category if there were a law against this, you'd be breaking it right now, but there's not, but there should be. We should be purchasing services by competitive procurement, and I think we can.

Massachusetts is very, very unusual

in the history of our country. The opportunity for us to do this is unique because of the facts that have been brought forth by the most recent Attorney General's report, by Attorney General Martha Coakley. That's a critically important document in history.

And by the findings and work of the Division of Insurance and the hearings that are underway and some of the facts that have been brought out, we have an unusual situation in Massachusetts. That is, we have very -- a preponderance of very expensive providers, teaching hospitals, physician's groups affiliated with teaching hospitals that have reached out to the community and as a result of this, there's huge disparities in the costs.

Now, under the Social Security Act that created Medicaid and under which Medicaid is authorized, there's a principle that every eligible recipient has the right to go to every eligible provider; free access is the idea. My -- this -- this waiver that I suggest that we would expand is a -- is the waiver that allows a state to limit that for various reasons.

So we apply for a waiver to the federal government to have patients who are participating in the MCOs to have a relative limited network that -- that required an exception. So my -- my suggestion is we do what other states have done -- some other states have done, but which I think would be highly successful here. That is we would competitively procure services that are susceptible to big differences and savings, and I would recommend that you would consider this as part of your current deliberations because it would help to ameliorate the issue of the subsidization by public payers in Massachusetts.

In other words, I believe that for a great percentage of -- of the business that Medicaid provides, that we would be able to -- to purchase it at much less but yet at high quality.

And let me finish by -- by citing some testimony that was educed by Commissioner David Morales during his recent ongoing work in trying to find ways to save money in our system, and it was testimony presented to him on March 5th by Network Health. And I -- I urge every person who is following this debate to read this submission that's available online by Christina Severin, president of Network Health, in which she lays out on behalf of a very, very, very good organization, the reasons why they're handcuffed in the operation of Medicaid.

And if you read that in -- in the -- in the light of what I'm talking about, I think there's a way for us to take advantage and reduce our costs significantly by having patients, our patients, go to high quality but less expensive facilities, and they would -- and we would say that's where you go. This -- this is the -- this is the set which the -- a physician, your physician, can send you.

The comment that is made by Christina Severin, the president of Network Health, concerns the fact that patients are -- have freedom of choice to go to any facility. Physicians have freedom of choice to send to any facility, and a great preponderance of their care is sent to expensive facilities beyond the control of the MCO, beyond the control of Medicaid, and there's a way to avoid that and I think we should, and I think it would be very lucrative and valuable without a diminution in quality.

Thank you very much for all the time listening to me, and congratulations on your work, Commissioner, and also Tom O'Brien and -- on behalf of my office to Attorney General Coakley for all the great work that your office did on -- on your recent two reports. Thanks.

MR. MORALES: Inspector General, thank you so much for your -- your comments. We will definitely take into consideration your ideas. I appreciate that.

So let's start with the public component of the hearing. What I will do is call each individual and every individual I call, please come to the podium, offer your testimonies. I'll respectfully ask you to keep it to three to five minutes.

Amy Kline.

AMY KLINE: Good afternoon and -- and thank you. As the commissioner said, my name is Dr. Amy Kline and I am representing the American Physical Therapy Association of Massachusetts. I am a member of the APTA, American Physical Therapy Board of Directors, our main -- national, as well as a clinical assistant professor at the MGH Institute of Health Professions here in Boston.

The American Physical Therapy Association in Massachusetts represents the Physical Therapy Association of the Commonwealth, and our members practice across a spectrum of healthcare delivery settings. We support the imperative need for the healthcare cost reform in Massachusetts and look forward to working with the administration and the legislator on appropriate reforms to slow the rise in healthcare costs while preserving access to care and the communities ability to choose their own healthcare providers.

We urge caution with any large scale refirms -- excuse me -- reforms, as a potential for unintended consequences is great. Some proposals have the real potential to force small providers out of business. We urge consideration of pilot programs, which can uncover unintended consequences before a large real-time deployment.

Many of our members practice in

settings of 50 or less employees. Thus our members are being squeezed from all sides in the current healthcare environment. Our members face double digit insurance -- insurance premiums, increases annually and have seen payments for our services from insurance companies, especially the Commonwealth, decrease relative to broad-based cost-of-living indicators.

Each year, insurers and the government add more unnecessary administrative burden. For example, most payers have their own documentation system and process to request approval for treatment. Cost of utilities, payroll, benefits, insurance and all other associated costs with operating a physical therapy practice have increased dramatically.

To bend the cost curve, the market dominants of healthcare monopolies must be reduced. Small physical therapy and medical practices are the only -- only competition to healthcare monopolies. Without adequate support, there will be no competition. This will reduce access to care and will drive up costs. More small practices will close and be forced to let go many workers across the state.

Without adequate safeguards, state -- state imposed fee schedules, global payment, capitation schemes will further consolidate the healthcare marketplace.

To insure stability in our healthcare service delivery, any state mandated fee schedule, global payment or pseudo-capitation scheme must contain the following safeguards: Allow patients to choose all of their providers, develop and deploy quality measures for hundreds of the most common health conditions and procedures across the spectrum of diseases and injuries.

A few metrics for a few or some chronic diseases does not make an alternative contract a valid method of improving broad-based healthcare quality.

They must be strict limitations on financial incentives to prevent unwarranted withholding of care.

The Commonwealth must closely monitor the hundreds of disease and medical procedure metrics for both over utilization and under utilization. Fee schedules must address prices, insure appropriate access to all services physical therapists offer and daily caps on payment should be removed or raised to insure fees for low-cost providers are not drastically reduced.

Physical therapists saved the healthcare system many times over the cost of providing physical therapy. We decrease the need for surgery and imaging. Our successful interventions enable patients to stop using expensive and risky medications.

Barriers to accessing physical therapists should be eliminated. These barriers are both administrative and cost. Many insurers in the Commonwealth force patients to needlessly spend money to see their primary care providers in order to access a physical therapist. This has cost and delays access to care.

Oftentimes, physical therapists can quickly and inexpensively resolve an injury or condition without the need for other healthcare services. Delays in obtaining physical therapy can complicate recovery and resulting in more lost time from work.

The APTA of Mass. supports the small business healthcare insurance group buying -- buying legislation. We believe this will level the playing field and reduce some of the burden on many of our members who own small practices.

We support full transparency in healthcare cost and pricing. Consumers should know before their out-of-pocket cost, the cost and services paid by the insurer -- insurers, preferably before the -- excuse me -- before the service is provided. Empowering the consumer with price transparency will facilitate market forces to drive healthcare -- to drive savings.

Electronic medical health records should be intra-operable and accessible by all healthcare providers who are caring for a patient regardless of the setting. Limiting access or placing barriers to accessing a patient's medical record by all providers results in poor communication, increased utilization and costs.

We look forward to working with the administration and the legislator. Thank you.

MR. MORALES: Thank you, Amy.

Next we will hear from Judith Rothchild.

MS. ROTHCHILD: Good morning. My name is Dr. Judith Shindel Rothchild. I'm an associate professor at Boston College School of Nursing.

Testifying on these weighty issues is something I'm very familiar with because

I've been doing it since the 1980s, Chapter 372, 574, 23 and in -- when we enacted in December 1991, Chapter 495.

I have to comment on a statement I made to the Senate post-audit committee in 1994, when I said, "Competition is a policy which gained prominence due to a lack of will to challenge a republican governor who had enticing economic theories that left weighty decisions about allocating health care to the free market instead of our elected officials -- or elected representatives and public officials. Too much is at stake to sit back and watch the scorpions battle until only one is left.

"Massachusetts is a leader in the nation for healthcare services; should be a leader in the nation for innovative healthcare reform. Hopefully, this hearing will begin that process."

Well, 16 years later, we have 97 percent of our -- our citizens covered through health insurance, and we have the dubious distinction of being one of the priciest healthcare providers in the country.

I have specific recommendations based on the AG's report that have relevance for nurses as the biggest providers of health care in the Commonwealth.

First, and I've talked to the commissioner about this, of the -- the conclusion that prices paid to hospitals are not based on the complexity or acuity of care. We, in nursing, firmly believe that DRGs need to be adjusted to include nursing intensity weights. New York State has such a system in place. It is my belief that that could account for about 13 percent of the variance, not 190 percent, but that's at least a step in the right direction.

One way of collecting that information that nursing is working on right now is to use an electronic medical record to -- to collect real-time nursing intensity information on a patient-by-patient basis. I think that's an exciting, easy to administer alternative.

The fact that there's no correlation between price and quality, and I really think that the hearings lacked an emphasis on quality and how are we going to measure quality. There's been a lot of focus on price. We have to have and expand that discussion on quality.

Nursing has done a lot of work on nurse sensitive quality measures. In the hearing yesterday, one of the hospital administrators said, "Can we please pare this down to just 15 that we can all agree with?" I'm actually very sympathetic to that, frankly.

I think nursing has contributed to this sort of burgeoning. I may be alone in this, of quality measures, but I'd like to talk to you about some key nursing quality measures, like failure to rescue, sepsis and RN to patient staffing. That's easy for patients and payers to understand. In the CCU, for 24 hours, every nurse is, on average, assigned 1.4 patients. That's simple and straightforward.

The prices paid to the networks that vary. I have spent the last two weeks since I knew I would be testifying here crunching information, looking at does nurses -- do nursing -- does it have any role in this variation at all? I couldn't find anything that related nurses' wages to what hospitals -- total hospital charges were or total hospital charges for separate medical procedures.

There were some other significant findings that I think are worth pursuing. Profit is tied to nursing wages; teaching status is tied to nursing wages. We've heard a lot about teaching burden, especially from Dr. Stu Altman, and we need to tease that out.

In summary, multiple commentators in these hearings have noted that market and regulatory costs containment reforms need not be mutually exclusively. I agree. Essential healthcare services should not be left to the whims of the free market, nor can regulation alone, and I think this is very important, properly align cost and quality. We have to have a discussion that balances those two interests.

Registered nurses are the largest group of healthcare providers in the Commonwealth. We have a very important critical role in identifying reforms for both universal access to high-quality, cost-effective care.

Thank you, and I submitted my comments and supporting documents by e-mail.

MR. MORALES: Thank you, Judith, appreciate that.

Next, Carol Allen.

MS. ALLEN: Good afternoon, Commissioner Morales, and Mr. O'Brien. Thank you for allowing me to speak today.

I'm Dr. Carol Allen. Excuse my frog

in my throat. I'm Dr. Carol Allen, president of the Massachusetts Chapter of the American Academy of Pediatrics, speaking on behalf of our 1700 pediatricians across the Commonwealth.

Our chapter and the American Academy of Pediatrics know the most effective and most efficient care for children is that offered through the medical home. Indeed, our chapter has developed a white paper on the pediatric medical home, which I will submit to you electronically.

A well-trained and experienced pediatrician practicing with a strong support team and partnering with patient's and parents to provide high quality and cost-effective care, because it is -- will provide high quality and cost-effective care because it is built upon a relationship of trust.

All payment mechanisms should reinforce and strengthen these relationships and shore up the foundation of the primary-care practice. We've heard a lot about hospital-based medicine, but their primary care is where most patients get their care.

Care management is at the heart of the medical home. Payments need to be adequate to provide support for care -- care management in the primary-care setting.

It should facilitate coordination of complex medical, social, family support and developmental needs, assess problems such as obesity, asthma, attention deficit and developmental needs and behavioral issues and cover the full range of preventive services that currently form the core of pediatric practice.

For pediatric patients, especially those with complex conditions, the payment system must also assure access to pediatric specialists and programs of demonstrated value, such as early intervention, must be supported and strengthened. Right now, there's a threat to cut back on early intervention.

As you know, most chronic diseases, heart disease, stroke and hypertension and diabetes have their origins in childhood, yet many insurers don't offer incentives to manage their precursors such as obesity, which has become an epidemic.

High-quality care for children provided through the medical home is inexpensive and improves outcomes. Indeed, investment in the health of young children is the best investment we, as a society, can make for a self -- for a safe and affordable future.

An ounce of prevention is worth a pound of cure. You've heard that, but it really is important to invest in prevention, including things like oral health and vaccines, and to maintain the strong public health support system.

Our chapter has worked closely with the Mass. Department of Public Health on obesity prevention and prevention of smoking and exposure to second-hand smoke.

We depend upon DPH to provide our vaccines and to give us regulations around their use, and we think that if you revamp payment systems but shortchange public health investments, that would be foolish and shortsighted.

To contain long-term cost -- costs, it's also important to invest in infrastructure for health IT so that systems and providers can communicate with each other. This would reduce duplication, which is a huge source of inefficiency in health care. Most -- most the HR systems aren't designed around the needs of pediatric patients.

While the Recovery Act provides funds to states to help with meaningful use of the HR implementation, a practice has to meet a threshold of 20 to 30 percent Medicaid population to qualify for the funds. Many Massachusetts pediatric practices would not meet this threshold.

To the extent possible, the Commonwealth should leverage the funds that are provided for meaningful use to establish supports that are available to all providers who care for children.

And because the mind and the body are tightly connected, our systems need to support collaboration between primary care and behavioral health providers.

Coverage for effective behavioral health management is likely, ultimately, to payoff in improved outcomes and reduce overuse of doctor's offices and emergency rooms.

There needs to be support for families in crisis and for medications when indicated. The MedPAC program that offers immediate psychiatric consultation to primary-care pediatric practices is a wonderful example of cost-effective acute-care management. This program, currently being downsized, should be supported or even expanded. And I want to say, "Personally, I think that medal -- mental health carve outs are a mistake and there really ought to -- somebody ought to rethink that whole system."

Finally, regarding global payments and accountable care organizations, our chapter urges that caution be used. Hospital systems and primary-care practices often have conflicting incentives so it makes a difference who is the primary recipient of the funds.

I believe, and I work for Harvard Vanguard, that's my disclosure, that the distribution directly to a provider system has a better chance of resulting both lower cost and healthier patients then if it's distributed by way of the hospital.

But in dealing with small practices, the devil will be in the details. They cannot be arbitrarily grouped, and they may fair poorly if they're aligned with hospital systems. So it's important to keep the patient clearly in mind when designing these systems. The incentives must be around collaboration, innovation and patient centeredness, ideally, provided in the context of the medical home.

I'm happy to answer questions, if you have any. Thank you.

MR. MORALES: Thank you, Doctor.

Robert Simmons.

MR. SIMMONS: Hi. Thank you for your time, Commissioner, Ms. Murray.

My name is Bob Simmons. I'm the vice-president and coowner of Boston Home Infusion. I'm also a registered nurse and a registered therapist.

When we started the company 18 years ago, we started the company servicing a population that no other provider would service in the Commonwealth at the time. Even companies that I was employed by, which were nationally owned providers, and that population was the Mass. Health population. We serviced communities throughout the Commonwealth, anywhere from Pittsfield to New Bedford, all the way up at Lowell and Lawrence.

So as a company, what we've attempted to do is, is to keep the clients at home. And this is a problem that I somewhat have. As a matter of fact, sometimes I think we should change our name to Boston Home Infusion Medical Center. Because, basically, we are a hospital without walls.

We employ pharmacists, nurses, therapists, dieticians, all the components to care for the clients outside the facility. Other than surgery, there's not much that we cannot do in the home, which is the most cost-effective platform around.

So I -- I really have a hard time understanding why this particular side of our -- of our health care is not being strongly looked at and evaluated, but instead is kind of like on the chopping block. Continually cutting the home healthcare side, medical equipment and/or services, things like that, is detrimental to health care.

When I tell you the fact of simple things like providing oxygen to a client at home is less than $10 a day, where in the facility, it's like $6,000 on a short-term stay. IV antibiotics at home, anywhere from $150 to $200 per day as compared to 1,500 to $2,500 a day. Now, call me "crazy," but I don't think you have to be a rocket scientist to figure out and -- and work the math.

As Ellen -- Ellen Zane said, "You know what? Low-cost providers continue to get persecuted," and we are a low-cost provider in this industry and we continue to get persecuted. We have to main -- maintain credentialing, joint commission status, all of the requirements like any other institution.

So my last comments, without wasting a lot of time, I don't want to be repetitive, is that we need to reduce disparities. We need to reinvest in the home healthcare product or model, and I'm more than energetic and willing to work with anybody and the commission to help because I think there's a -- it's a value-added service to reducing our healthcare costs.

Thank you very much.

MR. MORALES: Thank you, Mr. Simmons. David Matteodo.

MR. MATTEODO: Thank you, Commissioner, for this opportunity to offer some comments.

My name is David Matteodo, and I'm the executive director of the Massachusetts Association of Behavioral Health Systems, which is an organization of 47 psychiatric and substance abuse hospitals throughout Massachusetts, and I appreciate this opportunity to give some comments. I've heard a few references today to be -- mental health, and that's great, Dr. Gottlieb, and one of the previous speakers. But I'll just give you a little framework as you kind of approach payment reform and how the -- how we see the mental health and the behavioral health system fitting in.

Basically, in Massachusetts, there's about 2,500 private beds in -- in my system. There's about 650 DMH state beds, so all together we are talking a little bit over 3,000 beds.

Our hospitals in the -- in the private sector are very heavily public payer dependent; we're between 60 and 70 percent Medicaid and Medicare. So the government is a huge payer. Our average length of stay is about 8 days, and we generally run about 80 to 90 percent occupancy.

The -- in the last couple of years, we've lost -- we're in the process of losing one of the child units. Some adult beds have closed, not a huge amount, however, surprisingly, we've four Geri psychiatric units open and we've had one child unit expand. So we're kind of holding our own. But it's extremely fragile, and the DMH now has closed -- to get down to the 650 beds, they will have closed 150 beds in -- in the last eight months. So it's a very fragile system.

Our system, we believe, is underserved, under funded and, really, over managed. We have -- the state has done, through the Mass. Behavior Health Partnership in the last few years, two independent analysis that show a gap of between 20 and 30 percent between our costs and our actual payments. So we're under -- we're under -- underpaid.

We're also very -- ironically, very heavily managed. There's carve outs. There's insurance companies. Our -- our -- we need preauthorization. We need concurrent reviews on a regular basis, so it's very heavily micromanaged.

And we have to fight for equity. We -- we just recently had a parity bill passed, which is great, but there's still our problems. Medical records is one, the stimulus bill that passed Congress earlier contains no money for behavioral health providers, just acute care and -- and doctors.

So what do we see in -- in this for you all that I would recommend? There's real opportunities here. The lack of integration between behavior health and physical health. There's real opportunity, the MedPAC program was mentioned earlier. We need more programs like that. The other thing that's very important to address this is because the mentally ill, the severe mentally ill, have a life expectancy of 20 years less than the average population. Obesity, diabetes, heart disease, numerous problems, if we can get the mentally ill -- not only mentally, deal with their mental situations but also their physical, it will save the state and the -- and the private sector a lot of money. So we think there should be -- I've heard some great ideas, lower administrative costs in the behavioral health system, give us some incentive to share the savings. If we -- if we can -- you know, there were ideas mentioned about holding providers harmless and then if they save they could share it with the insurers. Ideas like that, I would think are -- are excellent.

And to sum up, we really think if there is a global payment system, that we should -- that behavior health needs to be part of it. We want to be carved in, not carved out, and we think that there needs to be sufficient behavioral health networks. I think we're moving as a country and as a state, certainly, in the last ten years, very, very far along in this area. We just need to keep it up.

So, thank you. I can write this -- is there -- is -- I meant to ask. Is there a time period for comments? Because I can write this up for you.

MR. MORALES: Yes, the 29th.

MR. MATTEODO: The 29th, great.

MR. MORALES: 26th. No, the 26th.

MR. MATTEODO: Thank you.

MR. MORALES: Thank you, Mr. Matteodo, appreciate it.

Next up, Karen Estrella.

MS. ESTRELLA: Good afternoon, Commissioner. Thank you for the opportunity to testify today. It's interesting listening to some of the other organizations and the similarities that we -- that we all have.

My name is Karen Estrella, and I am the executive director of the New England Medical Equipment Dealers Association. Our members in -- we're a 68 association and our members provide durable medical equipment, home oxygen therapy, home infusion therapy and custom wheelchairs in the six New England states.

Our members are also heavily dependent on Medicare and Medicaid. Those are the two biggest payers for our members as well. And our industry is similar to some other groups that spoke, heavily regulated, intense document requirements. And then at the same time, we've been having numerous reimbursement cuts over -- you know, over the years from -- from all -- from all payers actually, but yet we know that home medical equipment and the services that our members provide are the most cost efficient way to take care of patients.

CMS administrators have touted the value of home care over the years. It's where patients prefer to be treated and it is the most cost-effective delivery of health care.

Some of the things I heard from the panel today that were interesting was that they wanted to see a more encompassing system. They wanted to see quality standards. It was interesting to hear one of the speakers talk about that there's too much care in expensive settings, and, again, that's where we feel our industry is -- will bring value to this discussion.

And I'll have to tell you, that we're an industry that's not well understood. I think a lot of people think we just drop off oxygen concentrators like the pizza delivery guy and that's it, but yet our members are hiring nurses, respiratory therapists, clinicians. They're in the patient's home. They're sometimes the eyes and ears of the doctor in the -- in the patient's homes for them.

But we haven't done a good job of being out there in -- in the public so that's why we're here today, part of the reason. And we are the smallest piece of the healthcare pie, but the return on investment, if you invest in our industry, is really, really huge.

And before I end, I -- so I'd -- we would like to work with you, Commissioner. We're looking forward to that. But one comment I would like to make with respect to some of the comments from the Inspector General's office about competitive bidding, that is -- that is a concern.

I understand that his thoughts are well intended, but they're having several economic studies on the negative consequences of competitive bidding for durable medical equipment industry, and I will provide those to you, Commissioner, for your review. That -- we believe that there's other ways that we can find savings and -- and contain costs than -- than going to competitive bidding. At least I can speak that for -- you know, for our industry.

Again, thank you for the opportunity today.

MR. MORALES: Thank you, Karen.

Next, Julie Lynch.

MS. LYNCH: Good afternoon. Thank you for this panel and for the opportunity to offer comments.

I'm offering testimony as an individual who's a nurse, a Ph.D. student researcher at U. Mass. Boston and as a family member of a cancer patient who has benefited substantially from the superior quality of cancer care offered by Boston area Comprehensive Cancer Center.

I have two main concerns about the discussions that have taken place over the last three days. Measures of quality in health care, particularly for terminal conditions that rely on cutting-edge clinical research are limited and therefore cannot be adequately linked to costs.

Patients can't always nor should always be held responsible for their health conditions. For anyone who has studied social determinants of health, the relationship between environmental conditions and the ability to live a healthy lifestyle is apparent.

I will first discuss measures of quality. As Andrew Dreyfus mentioned yesterday, we do not have good, well-defined measures of quality, particularly in cancer care. I'm on the health equity committee at Comprehensive Cancer Center, and this is an issue we have struggled with in the development of our health equity report. While I'm confident that our community hospitals offer equal, if not superior care for certain conditions and procedures, I know through personal experience and professional research for some cancers, the evidence clearly demonstrates that care in a Comprehensive Cancer Center is superior.

In Massachusetts, 40 percent of African Americans obtain lung cancer care at community hospitals. Community hospitals are not offering lung tumor genotyping services to guide treatment. This is a problem, particularly for after African Americans who are not benefiting from targeted cancer therapies to the same extent whites are and are dieing sooner as a result.

Therefore, I believe the relationship between cost and quality has not been fully explicated, and I'm concerned that without good measures of quality, cost pressures will result in an exacerbation of race, ethnic and socioeconomic disparities in healthcare.

And I want to address the second point. It is naive to think our healthcare cost problems can be addressed by individuals simply modifying their behaviors. Environmental factors contribute to poor health. Poor and minority neighborhoods do not have access to fresh produce, safe walking or running paths, and these neighborhoods are exposed to significantly more alcohol and tobacco advertisements.

Lung cancer is frequently cited as a disease that is due almost exclusively to behavioral choices. This is a good example of an oversimplification. 16,000 to 24,000 patients per year in the U.S. who have never smoked die from non-smoking lung cancer. If this were categorized as a separate cancer, it would be among the top ten cancer killers.

I sincerely hope that whatever policies the state developed to address rising healthcare costs, they keep these issues in mind.

MR. MORALES: Thank you, Julie.

Next, Benjamin Day.

MR. DAY: Good afternoon everyone who's survived three days of public hearings.

My name's Benjamin Day. I'm the executive director of Mass-Care, which is the single-payer healthcare campaign in Massachusetts.

We -- obviously, we spent a lot of time trying to win universal single-payer style health care, but we also work on a range of cost control issues that we think will point us in the right direction.

Most recently we've been focused on prescription drug costs, which I would note, have been sort of conspicuously absent from these hearings about how to control drug costs.

The -- the -- the division's recent report said that drug costs are about 20 percent of our total healthcare spending. That's more than we spend on inpatient care, and it's close to what we spend on outpatient care. So I think we are going to have to focus a little bit more on prescription drugs.

But just to back up a little bit, I mean, anyone here who's been following the national healthcare debate for the last week or the last year or the last 20 years may be despairing that we Americans are not very good at healthcare reform. But there's actually been a lot of states that have passed various sweeping healthcare reform, not just Massachusetts, but Ten Care in Tennessee, the Oregon basic health plan, Wisconsin health rights, Dirigo Health Plan in Maine. These were all actually hailed as universal healthcare bills when they were passed, over a dozen states, but you may not remember them with much clarity because they all failed to control healthcare costs. And with rising healthcare costs, all of their gains covering the uninsured were wiped out between three and five years.

I wrote a paper with a couple of Harvard Med School researchers on how these laws have all failed over time because they didn't control costs. So it's not that we're bad at healthcare reform, we're really bad at healthcare cost control, and I think the reason is that we rely on the healthcare industry almost exclusively for job growth and economic growth, and we just can't have our cake and eat it too in this respect. And along with that, you know, that fact makes it very politically difficult to pass healthcare cost controls. But I think it also means that we've passed a lot of cost controls that simply don't work or don't work on a scale that will actually be noticeable to bend the cost curve.

We have extensive evidence with rate setting, with chronic disease management, with health IT, with limited networks, capitation, managed care, pay for performance, prior approval of premiums even, managed competition, which was the big thing in the 1990s that didn't work, and there's very -- we -- we tend to pass cost control that is not based in evidence that it will actually work and it will actually get us to -- to a sustainable health care system. And I think we're in danger right now of -- of -- of moving towards policy solutions that don't reflect the evidence that we've just got from these two amazing reports.

And I think the -- the biggest lesson from these two reports that I took away was that our high and rising healthcare costs are not due to high and growing utilization. It's not because we are using to much care or more and more care;

it's because of unit prices that are -- that the care we do -- do -- that we do receive costs too much. And yet the primary policy instrument that we've been talking about the last three days, which is moving from fee for service to capitation, is basically designed to reduce utilization.

You know, maybe I'm missing something here, but it seems to be off the tracks a bit. And there's very, very little evidence where it's been put into place that switching from fee -- I mean, we all know that our fee-for-service system is broken. We all know that it leads to over utilization, but we also know that it is not the -- it is not the primary driver of our rising healthcare costs, and fixing it is not going to fix our cost problem. And I've listened to quite a few witnesses over the past two days trying to square this circle and it seemed everyone has pretty much said, "Well, we -- we need to do it, but we're going to need to do a lot more than that." So I think it's the more that's important to focus on right now, and it has -- that -- the more is what has to be evidence based. It has to be what we know has worked in other places in bending the cost curve.

And for that, I'm going to quote two other folks who you probably trust more than me, Stephen Sherenbaum, who testified yesterday from the Commonwealth fund. He was asked a question, which is has there been any country in the world that has successfully controlled costs without having a global budget? Essentially, the state budgeting the entire healthcare system, and his -- the answer was no. No state has been able to do it without either a single-payer system or putting a private insurance system under a global budget and heavily regulating insurers.

And there was another great paper that was published by Theodore Marmer and

Jonathan Oberlander and a couple of others at the outset of this national round of health reform, and it was titled "Obama's Options for Healthcare Cost Control, Hope Versus Reality," and they basically said, "You know, we hate to break this to you, but almost all of the cost control measures you've been proposing have been proven not to work, and pretty much the only option is to have something like a global budget and heavy regulation of the insurance industry as other countries have," which is the same thing that Stephen Sherenbaum said.

So, you know, I would just remind us that we have a very short timeline on this. The payment reform proposal has been talked about as our long-term proposal, that it will take five years. Five years takes us to 2015, and if you remember the Len Nichols graph on the first day here, 2016 is when we hit 34 to 45 percent of our income, which is unsustainable. So we only really have a very short timeline to get cost control right before we hit healthcare Armageddon.

So I -- I really hope that it will be evidence based this time, and I think the bad news, unfortunately, is that we're going to have to do a lot more than is currently politically comfortable to actually get effective cost control that works.

So thank you very much for your consideration.

MR. MORALES: Thank you, Ben.

Eric Linzer.

MR. LINZER: Good afternoon, Commissioner Morales, Division Chief O'Brien. Thank you for the opportunity to testify this afternoon.

For the record, my name is Eric Linzer. I'm the senior vice president for Public Affairs and Operations for the Massachusetts Association of Health Plans. We're a nonprofit trade association that represents 11 health plans that operate in the state. We appreciate the opportunity to testify, in particular because we were strong and early supporters of these hearings and the reports that have come out. We commend you, both your offices and the work of your staffs in terms of putting this information out there because we recognize that keeping health care affordable is the challenge facing all of us in health care.

But the other piece to remember is that health insurance premiums and medical costs are inextricably linked. As these reports have indicated, the major contributing factor to the increases in premiums have been the rising cost of medical services charged by providers. As has been noted, the bulk of premium dollars, nearly $.90 on the dollar, pays for medical services such as doctor's visits, prescription drug coverage, hospital stays and other services that benefit consumers.

So while utilization has been a contributing factor, the major factor has been the price of services. So any serious discussion about keeping health care affordable needs to start with what we pay for care.

As your offices start to think about and turning your attention towards solutions for making healthcare affordable, we'd like to offer five steps, both short term and long term approaches, to include in the final report.

First, is passing the affordable health plan. House Bill 4452 filed by Representative Harriet Stanley and Senator Richard Moore would provide small businesses with significant rate relief.

It does three thing. First, it sets a standard benefit product consistent with the Commonwealth Choice bronze level product.

Second, it limits reimbursements to

providers for this one product, no more than 10 percent above Medicare, and, third, it would cap health insurance profits to no more than 2 percent for all small products offered in the small and non-group markets.

Taken together, this would reduce premiums for individuals and small businesses by as much as 22 percent. But in addition to that, it would also provide a -- you know, address some of the market challenge issues that folks have talked about earlier today.

Two other -- two other pieces, and we'll provide the remainder with our written comments, is that we think that there needs to be a statewide healthcare planning process. As has been discussed over the last couple of days, the medical arms race has contributed to both increased utilization but also increased prices, and we think that going forward that one of the recommendations should be that there should be a planning process to coordinate both the availability of services but also where these services are provided so that as was discussed yesterday, we eliminate some of the duplication of existing services that ultimately lead to increased costs.

And, finally, with regard to payment reform, while we support payment reform and recognize that there -- there are challenges in terms of getting to where we want to be in the next five years, we think the state could begin this process by outlining a series of recommendations that set clear performance goals and benchmarks for reducing state per capita healthcare costs to no more than the national average and outlining measures to ensure the payment reform does not lead to higher prices and further provider consolidation.

We appreciate the opportunity to testify today and be happy to take any questions. Thank you.

MR. MORALES: Unless there are any other

folks that want to testify, we'll move on promptly to Assistant Attorney Tom O'Brien, who will conduct two examinations. This is Mr. O'Brien.

MR. O'BRIEN: Thank you, Commissioner Morales, and thank members of the public who testified.

At this time, I would call Paul Levy forward and ask that he be sworn in for examination.

I'm going to move around to your side of the table, Paul.

BY MR. O'BRIEN:

Q. You understand that you do remain under oath?

A. Yes.

Q. And were there any conflicts or other types of limitations that you wanted to note for the record?

A. There are none.

Q. There are none. Thank you.

Before we begin, I just wanted to, again, thank Commissioner Morales for the scheduling of these hearings and for the legislator for setting up the opportunity to evaluate the healthcare marketplace cost trends and cost drivers.

On behalf of the Office of the Attorney General, I want to thank the payers and providers who provided information, two of whom I will examine this afternoon from Tufts Medical Center and from Beth Israel, with regard to the information that we reviewed.

What my -- the approach we'll take, and, hopefully, it will help illuminate some of the things that we have heard already, but to have experts in the field look at some of the issues that have been found both in the Attorney General's report and the Division of Healthcare Finance and Policy's report in a linear way. And, hopefully, it will help expand upon some of the comments that -- that we have heard both through the experts but also some of the important comments that we heard from Julie Lynch just a little while ago on social determinants of health, some of the comments we received on behavioral health and the issue with regard to home health as part of a broad discussion to look at cost trends as we go forward. So to the extent that you can keep those in mind, I think it will be helpful to this examination to be a useful process.

So, I begin with my first question, which is just for identification purposes. State your name and a bit about your background, for the record?

A. My name is Paul Levy. I'm president and CEO of Beth Israel Deaconess Medical Center. I've been in this position since January of 2002.

Before that, I served a number of positions in both the private and public sector. I think the one that might be helpful and -- and relevant here is for several years, I was chairman of the Department of Public Utilities in Massachusetts and, therefore, served in a regulatory role with regard to rates and -- and conditions of service of electric utilities and regulated common carriers in the State of Massachusetts.

Q. Before we go on, just a follow up on that last comment. If you could, just based on that experience, indicate what is a utility and why is it regulated?

A. Well, generally, the economic theory that -- that arises behind regulation of utility companies is that utilities became regulated by the state governments for several reasons, one of which, which does not apply in this case, but as I will suggest is not so important one, is that the utilities were granted guaranteed franchise area to -- to serve.

The others were that they provided an essential public service, that they were capital intensive and, therefore, required an assurance of a return of capital and a return on capital for long lived assets.

Another was that there was a public expectation that the pricing of electric utility services and natural gas services, for example, would be nondiscriminatory, that it would not be based on the market power of consumers, their status in society or other factors not having to do with their underlying of use and cost characteristics so that nondiscrimination of pricing was deemed to be in the -- in the public good, all those things together. And there are probably other factors now that I'm -- I'm forgetting about. Motivated state legislators -- legislatures throughout the United States in the early 1900s, to create public utility commissions, to regulate those utility companies, establishing what is now called "a social contract" where the utilities had an obligation to serve at certain levels of quality. In return for that, they would have a reasonable opportunity to earn a good return on investment, and the balancing of that -- of those various interests would be carried out by a quasi judicial body operating under principles of administrative law subject to judicial review generally appointed by a governor but sometimes elected by the population. So in a nutshell, that's what public utility regulation is about.

Common carrier regulation is similar in nature, although unlike public utilities with guaranteed franchise areas, common carriers tended to provide a service. For example, the telephone company and -- and, indeed, trucks and busses at one point in our lives, were, likewise, regulated for similar reasons.

Q. And if I -- just building on that, obviously, the Commonwealth has a history of auto insurance regulation, which as I -- which is it born out from the same type of factors or is it a mandatory obligation for consumers to have the insurance?

A. I'm not that familiar with the history of auto insurance regulation, and over the years I've had trouble understanding it as -- as a driver, but I'm sure there are similar elements. That is to say what amounted to an essential public service because of a requirement for people to have -- to have insurance, a desire on the part of legislators and governors to balance the rather small purchasing power of individual customers against the larger selling power of -- of larger insurance companies and having participated in some of the auto rate hearings over the years as an expert witness setting up a similar quasi judicial function to review the reasonableness of rates and having that subject to judicial review.

Q. And just if there are a corollary between that -- those markets and either the health insurer marketplace or the provider marketplace? And when I say "provider," I'm talking about -- I'd ask you to focus on larger licensed health centers and hospitals.

A. I've come to believe that there is an analogy to be made. It's not a perfect analogy, admittedly, and that hospitals and physician groups don't have guaranteed franchise areas, but they do have geographic areas in which they are most likely to efficiently operate. And in some cases, as we've seen as the evidence has been presented in -- in this set of hearings, providers, which is to say "hospitals and physician groups," can essentially serve in a monopoly kind of role for at least a portion of the spectrum of care.

You might have an isolated hospital, for example, in the -- in a town in western Massachusetts or southeastern Massachusetts that has an essential monopoly with regard to secondary care, although patients might be transported to a tertiary center for the -- for secondary care. That would be, clearly, a geographical likelihood that they would provide -- get their care locally. Likewise, people seeing their physicians, their primary care and local speciality care, may face what amounts to a monopoly.

And then in the -- in the bigger Metropolitan area, the Boston area in particular, we've seen how there's a difference in market power and dominance of -- of provider groups, even in the Metropolitan area. And although they don't have a monopoly, there is clear market power. And what I would suggest is what congress call "a lack of contestability" where the business of taking care of patients in those tertiary centers, and for that, you have to look at the underlying structure of the industry, which is that the tertiary hospitals are, referral centers. They receive their patients, for the most part, not exclusively but for the most part, by the referral network of -- of primary care doctors, specialty -- specialist doctors in the community, community hospitals that have chosen, over time, to affiliate in one way or the other with the major tertiary centers.

In the case of the Boston metropolitan area, the larger such system, the partner system builds that affiliation network in great measure through ownership of physician organizations, physician practices and community hospitals, creating a single -- in essence, a single, bottom-line relationship among all of those affiliated participants with the tertiary hospitals. That's a very strong business and commercial incentive for all of the participants in that network who send their patients to that particular tertiary center or -- or to tertiary centers.

Other networks -- other hospitals in the Boston area, such as Beth Israel Deaconess Medical Center, and not to speak for -- for others that I don't run, but my impression of Tufts Medical Center, and I know no one's in here so they'll testify later, and Boston Medical Center is that our referral business tends to come from community hospitals and physician groups that we don't necessarily own. We might have some ownership interest. For example, BIDMC actually owns Beth Israel

Deaconess Hospital in Needham, but that's the only hospital -- other hospital we own.

We do own a number of primary care practices, but many of the referrals we get are not from organizations that -- in which we have an ownership interest. We have relationships based on -- on strategical alliances and clinical practices, but nonetheless which served to in great measure provide referral business to the tertiary center.

So if you look at that kind of market structure, while it's different from the public utility structure or the common carrier instructor, you can see that there's a potential and, in fact, I believe the actuality of market dominance in that setting, which then provides what could be viewed as undue market power in the relationship between that dominant provider and the insurance companies with which it negotiates reimbursement rates.

I think we heard yesterday from Andrew Dreyfus and I think the day before from Jim Roosevelt, Andrew with Blue Cross Blue Shield, Jim at Tufts, and I had heard previously from

Charlie Baker when he was head of Harvard Pilgrim Healthcare, that they basically felt that they did not have sufficient market power to offset the dominant market power of the partners' system in the rate negotiations that would take place.

A similar result of things with regard to other providers, vis-a-vis, Blue Cross Blue Shield in the reverse direction. Blue Cross Blue Shield being the dominant insurance company in Massachusetts, having more subscribers than all the other ones put together, as I counted them recently, provides Blue Cross Blue Shield with a dominant, powerful position when we are negotiating with them for our reimbursement rates. And so there's an interesting shift of power, depending which side of the negotiation you're on and which -- which party you are.

I was actually a little surprised -- just an opinion, I was a little surprised to hear Andrew Dreyfus yesterday saying that Blue Cross didn't feel they had sufficient market power to withstand partners in a negotiation because

I -- from where I had always sat, I viewed them as roughly equivalent in terms of their relative market power, but I -- I believe in what he says when he -- when he says that. In any event, to the extent they don't believe they have sufficient market power to offset partners' market power, they clearly can't exercise such.

But the point is we have imperfections in the healthcare marketplace among the major tertiary centers and the major insurers in Massachusetts and, indeed, not only the tertiary centers but the networks affiliated with them, which suggest to me that left alone, the -- the reimbursement setting process, the negotiation process, will fail to produce an economically efficient result. And I believe the data collected by the Attorney General's office and the -- the data collected by the division in -- by -- and the witness testimony in this proceeding has basically documented that. And as a matter of economic theory and regulatory practice and market organization, that is not a surprise.

So I think the question before the Commonwealth, its citizens and the legislator and the governor is whether they are content with that result, whether that's the public policy result that we want for the people of the state or whether we need greater state supervision of that reimbursement rate setting process?

Dr. Sherenbaum, yesterday, suggested that in his view, state regulation of some sort more than exists today is necessary to produce an economically efficient result, a societally desirable result, and I agree with that.

Sorry to go on, but you gave me an open-ended question there.

Q. What I -- what I'm going to do at this point is I'm going to ask you a series of questions with regard to the particular reports, but I -- I am going to work with the time we have, and we set aside an hour for this, to get back around to whether it's -- whether you view it as little open-ended questions, but certainly back to the issue of social determinants of health and some of the issues of estate health planning and how that might be in the context of -- of whether regulatory or non-regulatory structures.

I would -- I would note before I begin these questions, though, to make a clear distinction, at least in the perspective of my role as assistant Attorney General is that to the extent that we are discussing issues of the particular power, which we call "market leverage" in the market and what we've examined. That's a very different concept than the analysis of market power under an antitrust analysis, which is a legal analysis which would require a different type of review and scrutiny. And I understand it's very easy for the language to -- to be mixed. But I did want to put on the record up front that I am not seeking and not directing questions towards an antitrust analysis but rather towards just kind of what the markets happening. Does that -- do you understand that difference?

A. Yes. And I -- although I'm a trained economist, I would not consider myself an antitrust expert, but I would, with some modesty, consider myself an expert in the regulation of utilities and like organizations.

Q. Okay. And I think that some of these other factors, you know, that I'll ask about might come back around to some of the -- some of the other considerations we've already talked about.

So, to start, the Attorney General examination of healthcare cost trends and drivers, which I'll refer to from here forth as just the AGO report, found that prices paid to both -- by -- by health insurers in the commercial marketplace, the hospitals and physician group -- physician groups, vary significantly within the same geographic areas and amongst providers offering similar services such as academic medical centers that provide tertiary levels of care, and that those differentials were not correlated by -- to a measurable quality to the acuity or sickness of the population being served to the amount of government payer business being served or to the status of the hospital as an academic or research facility. Does that finding, those series of findings, comport with your experience and that of your organization?

And I would note, also, one additional thing that we lawyers like too note things probably to often, and I know you have counsel with you, but this examination of you as Paul Levey, to the extent that I will site to the rule of civil procedures, this isn't a 30(b)(6) examination. I'm not seeking to have Beth Israel restricted by your answers. I just wanted to make that clear on the record.

A. Thank you. Before I answer, let me just say the basis for my knowledge in answering these questions is being chief executive officer of our hospital. As such, I am kept well informed of our negotiations with the insurance companies and also reasonably well informed of the negotiations of our physician organization with those same insurers.

For the most part, I do not participate personally in those negotiations, although I do from time to time. And so there are details of those negotiations that I probably can't answer, but I think I have a generally good sense of what's going on.

The answer to your question is yes, the finding does comport with the experience of our organization, and I would say -- I would say so based on a number of conversations that I've had with insurers themselves and with our staff about the manner in which negotiations take place.

And those four characteristics that you mentioned, quality of care, sickness of the population served, Medicare, Medicaid and the academic teaching rise to different levels of discussion during those negotiations.

Quality of care is perhaps the least discussed item in the negotiations. Sometimes there will be a pay-for-performance component of -- of an insurance contract, but it's actually a very small component, and I cannot recall of a -- a time in which our relative quality of care, as a general matter, for our hospital compared to other like hospitals has ever come up in a positive way, that is to say in affirmative way in -- in the negotiations. And I know that because I've raised that myself with the insurers, saying that given the -- the very strong programs we have in our hospital to reduce harm, to improve quality and safety, shouldn't there be some recognition of that in -- in the rate setting process, the reimbursement rate setting process? And not once, really, has an insurance company responded -- responded in the affirmative to that other than saying, "Well, we'll put in some pay for performance metrics." So both on a nominal level of our own hospital but also a relative level compared to other hospital, it is not an issue.

The sickness of the population served or complexity of the service provided, once again, I do not ever recall that that has been a factor in the relative rates that we receive compared to other hospitals or other physicians within the DRG schedule and so on. There are -- there are relative rankings of that, of course, but not when you compare the -- the -- not when you try to correlate our reimbursement rates with those of other hospitals and physician groups.

The extent to which a provider cares for a large portion of patients on Medicare and Medicaid, there is a component of our negotiation which attempts to recover the shortfall in Medicare and Medicaid payments from the government through the private payer rates. And I think, as we'll talk about later, a component of the rate increases that have existed over the last several years is to makeup for that shortfall, but I've -- I've never heard it phrased in terms our -- of our relative amount of such service compared to other hospitals. It may somehow be built into the rate-making methodology but has never been made explicit to me.

And whether a provider is an academic teaching or research facility, clearly, we do have provisions in our rates that recognize the fact that we're a teaching hospital. We do not have a recognition in our rates that we are a research facility, but I think your question is whether the comparative rate of academic teaching in our hospital compared to other academic centers or to non-academic centers, once again, has never been put forth to me as a factor in establishing our rates relative to those of other hospitals.

Q. And, again, just drawing on the public testimony, and I -- I don't remember who to really attribute this to and that's probably best in this examination process, while there was some examination through this -- this hearing process of quality, and clearly we looked at -- the Attorney General's office report looked at various quality measures that are out there, there -- the critique from one of the public speakers, there hasn't been enough focus on quality. And so I -- I would ask you what -- what is the kind of right sizing of quality measures, in a way, that could become transparent?

A. Well, there's a lot of debate on -- on what would be the appropriate measures of quality that one could use for -- for rate setting purposes. I think Blue Cross Blue Shield and their Alternative Quality Contract has come up with a number of metrics, and I think there are some generally accepted ones, which, of course, are not coming to mind right now. I'm happy to

provide later. But the point is, thus far, whatever you think they might be, have not been prime determinants of the relative level of rates paid among facilities or physician groups. It's just not a big factor at all.
Q. And, again, I understand that you don't have current recollection of the quality measures and the DQC contracts of Blue Cross. Do you have a current opinion as to whether some -- directionally, some of those measures are the right measures?
A. Well, I think they're -- they're grossly appropriate but maybe don't tell the whole story. For -- for our hospital, we've adopted a strategic plan and have a board vote that is directed to eliminating preventable harm in the hospital. That would be harm that comes from hospital acquired infections. That would come from falls, other metrics like that. In fact, you can go to our website, BIDMC.org, and see those listed.
We believe as a -- as a primary measure of quality, reduction of harm is -- is tops because after all, hospitals are supposed to be

in the business of making people better rather than harming them. And we believe that if a hospital focuses on reduction of harm, that other quality metrics follow.

There are others that are -- that are used regularly. For example, in particular service areas, there's something called "door to balloon time" in cardiac care. If someone comes in with chest pain, there's an expectation and a hope that that person would be seen in a cath lab within 90 minutes. And one of the metrics that exist is what percentage of the time do your patients who show up with chest pains have their catheterization within the 90 minutes? Many of us shoot to -- to reach 100 percent on that. In fact, our hospital has been at 100 percent on that metric for -- for quite some time.

Likewise, there -- there are other metrics, elimination of central line infections, elimination of ventilator associated pneumonia and the like. So they're both -- they're gross -- gross measures, but they're also service specific measures that can be used.

I think the thing to recognize at this point is that every hospital I know keeps track of these things, virtually, in real-time, month-by-month, week-by-week, day-by-day. So this is not a matter of asking hospitals to collect new data on new metrics. These are generally excepted metrics. We have the world of expert organization on healthcare quality in Massachusetts at the Institute for Healthcare Improvement in Cambridge. They have a list of things by which they think hospitals should be judged. I don't think we have to go very far to figure out what to do here.

Q. And as far as the transparency that the website that you have provides that information, do other hospitals provide that same type of transparency of their measures?

A. To a greater or lesser extent. I notice that Mass. General, for example, publishes its door to balloon time. I noticed they were at something like 73 percent compliance with the 90-minute standard. Mount Auburn Hospital does an excellent job publishing its medication error rates. New England Baptist also does that. So it's to a greater or lesser extent. I'd say for the most part, lesser extent. But that's -- that's a matter of choice.

Once again, all -- I believe all the hospitals collect these data, whether they choose to publish them or not, thus far, has been voluntary.

Q. If -- if we're trying to get a more value based system for the economy, whether through regulation or transparency, would the required standardization of some of those measures, if they're not already by these well-respected entities, and the public reporting of those measures be a step in the right direction?

A. Well, that would be an essential thing. You'd have to pick which metrics you want to use and you'd have to be open in public about the hospital and the physicians' group success in meeting those metrics.

Q. Would the -- obviously, we're trying to put it in the context of value. Would the price or some form of price relativity also be an essential element as far as the transparency?

A. I don't know. You mean -- I'm sorry. I was misinterpreting your question. I thought you were asking whether -- whether quality is an essential component of pricing, and -- and I was going to say in response to that, that sometimes mere transparency of quality metrics acts to improve quality. Although to the extent you can tie it to pricing, that gives it an additional incentive.

On the -- on the direct question of -- of pricing transparency, we currently operate under a system in which pricing is hidden from everybody. And if -- if you adopt my more public utility view of these essential services for the population of Massachusetts, it's hard for me to understand why the pricing between a given insurance company and a given provider, provider group, doctors, should be -- should not be open and public at this point.

I know we'll talk in a minute about other state actions that could take place to improve this overall marketplace. The -- the mere existence of sunshine on the rates that are charged and collected between insurance companies and providers, I think, would create a -- what amounts to a moral force that would help alleviate some of the market power issues that we're seeing demonstrated in your chart prepared by the Attorney General's office. Because then, frankly, if you were in a negotiation, you could at least ask the question, why is my rate different than somebody else? And it's really hard in that environment to just say, well, the difference is totally because we think they have more market power, although that could still exist as -- as a component.

So I think transparency is -- would be valuable. I don't see -- to -- to turn the question around the other way, I don't see a downside from transparency of pricing. I don't see how society loses.

Now, I understand Mr. Dreyfus, yesterday, said he was concerned that open pricing would lead to a race for the summit, that everybody would move up. Well, I think what it would move towards is to the median rather than to the top or the bottom. Because I think transparency of pricing works, to a certain extent, to the advantage of lower paid providers, but it also works to the advantage of higher paying insurance companies at the two ends of the spectrum. So I think it would be a regression towards the mean rather than towards the extreme.

Q. As far as pricing, it might be -- so instead of it being inflationary to the market, there might be some convergence around a mean as far as pricing?

A. I believe that would be the case, but that's a judgment call, obviously. But I -- I think generally in markets -- you know, if you go back to the economist definition of a market where you have knowledgeable buyers and sellers about the quality and price of what's being offered, markets tend to move towards an efficient price, not a monopoly inspired price but an efficient price.

Q. In the absence of market controls, I think the two concerns that I had heard raised this week or that I believe were raised this week was one that might have an upward pressure on those who are at the lower end of rates; the other, which you've addressed, the other was that if there isn't consumer incentives, it might actually drive volume towards more expensive centers. Because without information, if it's more expensive, the perception is it must be better.

A. Well, we -- we talked about that at our panel the other day, about the difficulty of insurance companies. I think Mr. Roosevelt was talking about this, offering a limited network product at a lower price because the public perception, as you suggest, is that the higher priced product offers more quality and more value in that respect. That's why accompanying price transparency, you need to have the quality transparency, because what that will indicate is more accurate -- a more accurate reflection of actual qualities of differentials among providers.

Right now, certain providers have a reputational advantage based on history, custom and the like, that may or may not be warranted based on what they're actually doing with patients. I would suggest to you, based on what I know about underlying characteristics of patient care in Massachusetts and Boston Metropolitan area, that the reputational advantage that is currently enjoyed by a number of providers appears to have no real basis in fact. And that's -- that's both with -- among -- within and among the academic centers relative to one another, but also between the community hospitals and the academic centers.

Many people who live in the outlying communities feel they need to come to Boston to have certain procedures done when they can be done just as well in their hometown. And the problem with that, of course, is they then move from a lower cost facility to a higher cost facility, helping to raise the cost of health care for all.

So healthcare price transparency and quality transparency would have the advantage of eliminating reputational advantages that currently have no basis in fact or might currently have no basis in fact.

Q. I'm going to -- I'm going to move on to -- from price to cost, and the Attorney General's report and also some of the comments by panelists this week have talked about how price variations, what's being compensated by health plans, isn't adequately explained by internal costs of the hospitals. And, actually, a panel the other day, I think it was Nancy Kane and some of the MedPAC Association talked about costing to price. Can you react? Is that consistent with what you've seen in the market?

A. Well, to the first part of that, the pricing is definitely not based on costs. That's proven in the data that you've presented in your report. It's also proven by the nature of the negotiations that go on between us and insurance companies. Very seldom are there any real questions about our underlying costs and our need for capital and the like.

The fact that some percentage of Massachusetts hospitals, I see Lynn Nichols here, maybe she can tell us the percentage, currently has a margin less than zero or an operating margin that is not sufficient to replace plant and equipment. That is to say it might cover depreciation but doesn't cover replacement costs as a prima-facie demonstration that insurance company rates don't cover costs of many hospitals in the state. And -- and if rates were based on costs, the hospitals in the state, generally, would be able to earn a margin sufficient to cover their reasonable operating costs and to return -- and a return of capital and -- for the future investment. That's the definition of a reasonable price in the marketplace. So that is the first part of your question.

The second part is whether people, in essence, in a hospital spend up to the level of the rates that they receive. And the answer to that is so that if someone is getting -- if some institution is getting higher than average rates, are they more likely to have higher than average costs? And as I think we discussed the other day during my testimony, if -- if that were not the case, hospitals with sufficiently higher rates would be earning super normal returns. That is to say their margins would be well above average.

It doesn't appear that that is happening, that they're well above average. So that suggests that they're actually spending the money they receive, both for operating costs and for reinvestment, expansion of facilities, building ambulatory care centers in Foxborough or Danvers or wherever it might be, because those funds are available to them.

Q. As far as that spending to cost, and you mentioned some -- some particular ambulatory centers. As far as various, and I know you have a wonderful chief financial officer and so they sent and I should pose these questions to him at some other time, but what other financial indicators that you look for in financial reports beyond operating margin, which would show the relative financial health, whether it's -- you know, some that I've heard are, you know, day's cash, capital ratio --

A. Right. Their ratios of debt to so-called equity, if equity is the right word for non-profits, day's cash on hand is important. The actual margin is important. The -- the annual capital spending relative to depreciation is important. I think the standard metrics that a bond rating agency would use give you a pretty good idea of the relative financial health of an organization.

With regard to -- perhaps a relative degree to which hospitals with higher reimbursement rates incur more expenses, you might look at the degree to which they find they need to subsidize government payers using private payer funds. Why is that a metric?

Well, if someone -- so the government payers, as we know, pay virtually the same amount to every hospital for similar services with minor differences and so on. So if two hospitals that are offering comparable levels of government service, Medicare and Medicaid service, and if one of them gets paid more by private payers than the others -- the other, and that hospital system has a relatively bigger deficit in recovering its cost from its Medicare and Medicaid rates, that would indicate that its overall cost structure is higher than the other hospital. And one of the explanations for that would likely be that they've incurred a higher cost structure because they know that the funds are available

to pay for that higher cost structure, if that was a clear explanation?
Q. Well, in -- in this particular proceeding, Beth Israel has filed margins for its commercial and margins for its government and margins for its other business.
A. Right.
Q. And some of the other medical centers have also filed similar information. So the extent that -- and, again, I'll just stay in hypothetical, that, you know, institution A had a -- a negative margin of 10 percent on the government business and hospital B had a negative 30 percent margin, that difference because of if they're both academic medical centers, would roughly equate to a cost structure difference?
A. I think it -- I'm not sure if it totally equates to that because there are probably other concerns. But I -- I believe it would be reasonable to assume that some component of the difference is related to the underlying cost structure of -- of the two hospitals.
Q. Beyond these types of metrics, how do we --

what ways could we advance the transparency of cost in the system? Right now, there are reports that are filed with the division for -- three reports, that some have suggested are limited utility. Can you give some sense as to whether you agree that they are limited utility, what can be done to improve the cost to the Commonwealth?

A. I'm not that familiar with the details of that, but I would just say that we had this issue with regard to public utilities and telephone companies and the like and even with the same set of accounts, there are -- there are different decisions made about how to allocate costs among those county wide. So I'm not sure what could be done to improve the current financial reporting other than to know in -- in pretty good detail what's in each line item so that you really understand what's there.

I know that we as a hospital try to look at benchmarks of -- of cost factors. I think many of us do this in terms of full-time employees per adjusted occupied bed and the like, pharmaceutical expenses per patient and -- and all those kinds of things, and there are benchmarks in metrics out there that we all look at, and then the next moment we say, "But they don't all apply as well." So there's a lot of judgment that goes into those kinds of things.

But in a way, you don't -- you and -- the state government shouldn't find itself beholden to a particular cost accounting system in order to solve some of the problems we've talked about with regard to market power. The mere transparency of the rates themselves, the reimbursement rates themselves will be helpful, and I have other ideas we can talk about as well, and you need to understand the cost accounting, but it may not -- may not tell you the whole story.

Q. Moving on, another finding from the Attorney General's report was that a variation in total medical expenses on a per member, per month basis wasn't correlated to the historical information as far as whether some entity was fee for service versus globally paid or adhered some risk in the contract. Was that finding surprising to you?

A. The degree to which there was a lack of correlation was surprising to me, because I've been hearing from a lot of people here in Massachusetts and around the country that the -- the answer to controlling healthcare expenditures would be to move to a -- more of a risk basis, a capitated or global system as it is now called. And I think your -- your data shows that that is not necessarily the case, and -- and your data was from 2008, as I recall; correct? So that it doesn't -- it doesn't yet include the new Alternative Quality Contract signed by Blue Cross Blue Shield for capitated rates. And my understanding is that in an effort to sign those contracts early on with certain provider groups and physician groups -- hospitals and physician groups, Blue Cross Blue Shield actually made it quite attractive financially to a number of those groups to sign on with not only attractive, initial payment levels but supplemental payments for infrastructure and the like that may not even show up in the rates per se.

And so I think if you were to -- it would be an interesting exercise to actually look at the 2009 numbers, too, that would -- and then include those new risk contracts to see if what you found in 2008, remains the same.

Perhaps over time -- I think the theory over time with the Alternative Quality Contract is that it would slow the growth rate, and that -- that may be the case. I don't want to say that it isn't, but I'm just saying for the data we have so far, I think you've demonstrated -- your office has demonstrated that that's not the case that it necessarily results in lower healthcare costs.

Q. Earlier, we talked about spending to price. Could this also be, to some extent, a result of spending to price, and, again, a total medical expenditure model as opposed to a reimbursement structure model?

A. I'm not sure, to tell you the truth, not that what I was saying before wasn't all the truth, also.

Q. The -- the division's reports and our reports, while focus on a particular timeframe, the last, two -- you know, three, four, five years, looked at the significance of -- of increases in price as well as the increases in utilization as important drivers of -- of -- of our current medical trend. Is that -- the significance of price in that equation something that surprises you based upon the experience of your organization?

A. I was a bit surprised by your conclusion and it wasn't until I talked to Mr. Fisher, our CFO, and we -- we went over it, that I understood how -- how you came to that conclusion. I think it's correct as it's stated.

I was surprised because when -- I know when we've put our budgets together and we've looked at increases in revenues for our hospital year-to-year, the growth in those revenues tended to be split more 50/50 between new -- new rates and utilization or demand. Whereas your numbers, I believe, showed rates being 75 percent and -- and utilization being more like 25 percent between, if I recall correctly.

But then Steve pointed out to me that the way you were looking at it also included -- in essence, included the shortfall in payments by the federal and state government through Medicare and Medicaid that then get rolled into the commercial insurance rates. So from the point of view of your organization looking at commercial insurance rates, if you then add in the shortfall for Medicare and Medicaid, it would look more likely that -- that price is a bigger component than -- than -- than utilization. But if you look at it from our point of view, on the ground, we were seeing it about 50/50. So I think -- I think the two numbers are compatible because of the different lens through which they've been viewed.

Q. And I just would note that the information that we provided, the Attorney General's report, was the -- the purpose was to hold up a mirror and report back what we heard from payers and providers as opposed to suggesting that one approach was superior.

A. No. That's what I'm saying. They're consistent. It's just my initial reaction when I saw them was, hmm, this doesn't seem consistent with the way we do budgeting. But then as Steve explained it to me, he said, "Well, it's perfectly consistent with what was said."

Q. But if -- if I -- if knowing where the -- what the components of trend are, obviously, important to the discussion of how to control trend, is there a way to improve, on a going forth basis, these will be annual hearings with continual scrutiny, that the issue is Blue Cross, in its mission to us and is included in the report, broke it up into price, unit price, a mixture of factors that they term "severity" and then utilization. How do we -- what is a way of reconciling where we're at that would be consistent with how Beth Israel uses --

A. I'm not suggesting it's inconsistent. I think the way you're presenting it is fine. The underlying question is perhaps the more interesting one to the extent that this -- these increases in costs are the result of -- I mean, is to look at the under -- of the components of cost increases to the extent, for example, that utilization of specialty services is growing, either as a result of demographic trends or whatever it is. The underlying policy question is what can be done about that?

There were a number of suggestions during this hearing that to the extent we could make it more attractive for primary care doctors, more feasible for primary care doctors to spend more time with patients, patients whose families they know and whose histories they know, and move primary care doctors out of their current what is often a triage function rather than a real patient care function. To the extent we could do that, it would help ameliorate the use of higher-end specialty care. As a societal goal, that is extremely desirable.

If you look at Europe and -- and other places, one of reasons they're able to control their healthcare cost is because they have very strong primary care systems and they make relatively less use of secondary and tertiary care.

So a question for the Commonwealth is how could we make that happen? Well, I would suggest to the Commonwealth that the

Commonwealth itself, as a purchaser, could make that happen.

Mrs. Mitchell was here from the Group Insurance Commission. They have a good deal of bargaining power with -- with regard to the insurance companies who provide that service. They -- they could say as a matter of policy we would like you to pay primary care doctors more for their visit so they don't just spend the nominal 18 minutes with a patient. Likewise, the state Medicaid program could do that. Likewise, to the extent the Connector Authority has this authority, it could require insurance companies offering the subsidized health insurance plans in Massachusetts to, likewise, pay primary care doctors more with the long-term benefit of reducing the higher-end secondary and tertiary care.

So we can -- we could actually do the laboratory tests of this theory right here in Massachusetts. Now, in the short run, it might increase costs because you'd have both the primary care network and the -- and the specialists in place, but over time, the theory goes, it would decrease cost. And if we're talking about bending the cost care over time, that, from everything I've heard from all the experts in the world that I've talked to, seems to be the primary way to get it built up.

Q. To follow up on -- on that answer, I think there's been a fair amount of discussion during this -- these hearings about a very hospital centric systems.

A. Yes.

Q. And, you know, we're -- you know, one of your earlier question -- answers talked about physicians, often specialty groups, aligning with hospitals, driving volume in certain directions. And whether it's, again, Ms. Lynch's comments or -- or Nancy Turnbull's comments about social determinants and kind of -- you know, kind of flipping the parodyne to some extent, how do we, either by -- you know, either with the -- whether the AQC can start to do that, whether payment reform can start to do that, start to get the -- the lens to be the right lens as far as starting from the patients' perspective with primary care?

A. I think we have to recognize with regard to the recommendations of the Payment Reform Commission and a suggestion that we move to global payments, that there are a lot of complexities with the movement toward global payments that the commission report did not address, that it explicitly decided to leave to the next group.

One of them, which is -- was discussed sometime during this hearing, was the idea that a move to global payment actually shifts actuarial risk from insurance companies to providers. I mean, that's the -- we call them "risk contracts" for a reason.

Now, to the extent that that's the case and to the extent that insurance companies can thereby shed risk, there should be a countervailing reduction in the capital requirements of those insurance companies and the savings from those capital requirements should then be passed along to the subscribers of those insurance companies. Thus far, no one has really talked about that savings and how it would be passed along. I'm just mentioning that as one example of the problems of moving towards a -- the recommendations of the Payment Reform Commission.

But to your underlying question, there are societal determinants of health that have to do with the way health care is delivered, but there's a bigger component, perhaps, that has to do with the way people live and the degree to which our society chooses to intervene in the way people live.

As a general matter, my belief is that our society does not like to intervene in the way people live by telling us what to eat, whether to smoke or not, whether to do things that we know could make people healthier. So the question is when you're dealing with the healthcare system, per se, as opposed to the public health system, when you're dealing with primary care doctors, secondary care, tertiary care, skilled-nursing facilities and the like, what recommendations or what policies with regard to the structure of reimbursement in that system make it more likely that the social determinants of health that are germane to that part of the system will be carried out?

One theory is that a global payment system would cause that to occur. Another theory is the one I stated before, which is -- which, by the way, may not be mutually inconsistent, to the extent we actually gave people primary care that properly served the primary care function, we might achieve a lot of those results, also, even under a fee-for-service system.

That's untested. Both are untested. My belief in public policy changes is that they should be done incrementally and carefully. There is nothing, even while we're considering where to go on global payments, there is nothing to prohibit, right now, the insurers and the state and Medicaid and the GIC and so on, from adopting an approach to reimbursement of primary care that would be consistent with the goals of payment -- the Payment Reform Commission but that don't require a reallocation of risk from insurance companies to provide. And so while we're waiting to figure out all the rest, why not move forward on that, as I said before, and do some

experiments and see if we can get some results?
Q. Would -- while -- while an important component of primary care is compensated, are there -- and whether that be primary care physician or RNs practicing as primary care --
A. Right.
Q. -- providers, how do we, in a sense, kind of the growth of that market?
Is it our academic medical centers? Are they producing physicians who -- or RNs that are focused on that work or is it just compensation, compensation, compensation?
A. Well, I -- I think people vote with their feet and if you look at the graduating classes of the medical schools, doctors are choosing not to become primary care doctors because they know that it -- it won't compensate them as well as -- as -- as other -- other specialties.
So if there were a long-term commitment and dedicated commitment on the compensation side, I think that would start to make a difference. Whether it would make a total difference or not, I don't know, but it's -- you can't force people to take on certain careers if they know

they can make more money being a dermatologist.
Q. As far as I -- because one of the findings of the Division of Healthcare Science and Policy was that -- that the -- we have a health system dominated by a higher number of specialty doctors just to --
A. Right.
Q. -- this point and by academic medical settings, both of which tend to be costlier -- provide costlier care.
I mean, is there -- should -- should either health plans or the system set limits on the relative ratio of primary care to specialists?
A. No. I think those will be derivative of the -- of the reimbursement system that's in place, whether the theory of the global payment system or the theory that I've just set forth about this compensating primary care doctors appropriately, is that so doing will result in less use of specialty care and that over time, the number of specialists as a percentage of the number of physicians in the state will drop, and -- and that will be the economically efficient, societal, desirable result, if we do

it right.
Q. And staying on -- on payment reform, one of the findings of the division' report -- reports was that the way healthcare providers are paid rely -- rewards those that provide a high number of individual services rather than those that are best at coordinating care and delivering good quality services in less expensive settings.
A. That's true, and -- and so the interesting issue here, we talked about this briefly at the hearing yesterday, there are many businesses, services and production kind of businesses out in the world that are totally compensated on a fee-for-service basis. Most other kinds of industries, if you think about it, are paid that way. We don't worry in those businesses about whether there's an economically efficient level of production of automobiles or toys or loaves of broad, all of which are purchased on a fee-for-service basis.
Why don't we worry about that? We don't worry about that because those markets behave like real market, for the most part. They're

not monopoly dominated. There's transparency of quality and price. I can go on the Internet and if I'm interested in buying a car, I can learn more about buying that car, its history, its reliability record, its price, its resale value, than anything to do with any purchase I make, any choice I make in the healthcare department. So, to the extent that we can move this system to more of a real marketplace, that will help in that regard.

Now, it probably is not the total answer, because it's the nature of healthcare that a certain portion of the costs are always hidden. We buy insurance. We don't necessarily buy the services we need when we're sick, and so there is not a direct correlation between my decision as a consumer to purchase a given service from the healthcare system and its price. There's always some intermediary in the way that -- that makes that not quite a perfect transaction. But we are so far from even close to perfection here in Massachusetts with regard to the reimbursement system, that there would certainly be some gain to our society in remedying some of the inequalities and disparities that the Attorney General has noticed -- noted in the report. So I would just say let's take it step-by-step.

You know, I -- I once said to our friends at Blue Cross when they were talking to me about the Alternative Quality Contract, you know, when you're an insurance company and the thing you have to -- to use to influence behavior is -- is the reimbursement system, it's like the old adage, when you have a hammer, everything looks like a nail. Of course, that's what they're focusing on, but there are other aspects of this system that can be equally important and that can be improved that may not require major changes in the day-to-day reimbursement scheme. I would -- I would precede incrementally and cautiously on it.

As I think Dr. Gottlieb said earlier today, there's a -- there is a danger in a global payment also of under serving the population relative to its medical needs. That was the -- the case the first time managed care capitated contracts exist. Presumably, we'd be better at it now, but we'd probably make other mistakes now. So as I say, I think as a matter of making public policy, it's better to do things incrementally. Evaluate, experiment and see how it goes before taking the next step.

Q. Speaking about experiments and the next step, Mr. Dreyfus did talk about the -- the number of entities or the percentage of the population that now under the AQC contract. Has Beth Israel entered in any AQC contract?

A. We've been in negotiations with Blue Cross Blue Shield for probably about two years now with regard to the AQC, and we -- we found them to be very difficult negotiations and perhaps the people at Blue Cross feel the same way, and we found them to be difficult negotiations without talking about particular numbers here because I don't think that's our intent here, the -- the hoped for trend in overall medical costs that -- that Blue Cross was aiming for us to achieve to make the AQC profitable, I use the term "profitable," in other words, positive margin for our organization, was -- has been, in our view, extreme relative to what they have been able to demonstrate to us is possible with regard to likely efficiency improvements in the delivery of care. In other words, we've said to them, "Show us, based on our current delivery of care to our patients, where we are out of line relative to statewide averages or even to best practices." And when we've compiled those results that they've given us and compared them to the pricing formula that they've proposed, it just hasn't added up. And so we have felt and, in particular, our physicians' organization has felt that it would be fiscally irresponsible to sign the contracts that have been offered to us so far.

We do not have a philosophical objection to -- to entering into risk contracts and so I want to make that clear, but -- but we have a financial responsibility to our organizations, whether it's our physician organization or our hospital. We do not have cash reserves of the type that an insurance company has, and when I talked before about shifting actuarial risk, that is a component of the AQC.

We've proposed an alternative approach to the AQC, which would be based on a cost sharing kind of approach of the kind recommended by Elliot Fisher at Dartmouth, where an annual budget would be set and to the extent we'd beat that budget, we would share the gains of beating that budget with the insurance company. The response from -- from Blue Cross Blue Shield has been to turn that down flat. We suggested it as an -- as an intermediate step along the path to an AQC.

We also, I should mention, in our discussions with -- with Blue Cross Blue Shield with regard to the AQC, now that we are further along in time than some of the earlier people who signed that contract, it's become very clear as I've talked to my colleagues around the state that those people who signed the contracts earlier were offered a more generous package than those who are coming along now, and I can't blame them for signing those contracts early on. Perhaps we should have done the same thing, looking back on it. But I think it's a fact of life that the -- perhaps it's a result of the financial condition that Blue Cross now finds itself in, but those contracts, the one being offered to us are clearly not as generous as those that have been offered to other institutions and physicians and groups previously.

Q. I have a few more questions --

A. Okay.

Q. -- and I know that the hour is -- and those bells weren't for us, I don't believe.

A. Okay. Ellen is patiently waiting there.

Q. But I -- we -- I want to ask you about some other findings of the division because I think they had a lot of the very important findings.

One of the ones, which is, I think, you know, kind of the -- kind of the capstone to everything is where medical trend is, and they found that between 2006 and 2008, private spending per insured individual health care in Massachusetts grew by 15.5 percent, more than 7 percent. Is that consistent with what your work shows you?

A. I don't know how to answer that. I know that -- I know that our budget has not

increased by that much, but we're not the
total -- the sum of all healthcare expenditures
in this -- in the state. And I have no reason
to question their number, but I can't say it
comports with the experience of
our organization.
Q. What -- what would be the -- I mean, obviously,
it's -- because it's statewide, it's built up
of a lot of pieces that aren't -- aren't even
hospitals.
A. Right. Nursing homes --
Q. It's nursing care facilities --
A. -- all kinds of things.
Q. -- and a lot of everything, a very
comprehensive review that they performed.
How does medical trend for your
organization compare to medical trend for the
statewide average?
A. I don't remember. I think we provided that
information to you, but I'm sorry I don't
remember it. We can get it for you.
Q. So it might be in the pre-file testimony
responses?
A. If it isn't, we're happy to get it to you.

Q. Do you think directionally, it's lower than that?
A. Oh, I -- I think so.
Q. All right.
A. It has to be because as I say, our -- our budget has not increased by -- by that amount per year and so it has to be different from that.
Q. Another important finding of the -- of the division's work was with regards to the trends of premiums, and I understand that your business is not insurance premiums --
A. Right.
Q. -- but rather running a hospital.
But their report found that from 2007 to 2008, adjusted small group premiums grew by 5.8 percent, midsize group premiums grew by 4.8 percent, and large group rates grew by actually higher than midsize groups at 5.4. That being so, the smaller the highest rate, large group, middle rate, and midsize group the -- the lowest rate. How does the experience of your organization comport with this?

And I'm going to -- I'm going to break one of the rules by asking two questions, which is, does your organization set rates or do anything differently depending upon whether it's a small group, midsize group or large group?

A. We negotiate an overall contract with the insurers, and then they determine their products that they sell to market, and we do not have an influence over how they price those products. So I can't answer your question in terms of how it comports with the experience of our organization.

We could get you, if it would be helpful, the experience of our organization as a self-insured organization with regard to our own employee increase in medical expenditures and, therefore, the -- what amounts to the implicit cost of insurance for ourselves, and -- and you could see how it compares to today's standards.

Q. And -- and just to make sure I understand the answer, that it's -- to the extent that there are rate differentials in the premium rates, it isn't flowing from any kind of negotiations.

Its negotiation, while it sets the -- the overall costs of services at your facility, it isn't differentiated by group size.

A. That's correct.

Q. Okay. We are coming to a conclosed -- conclusion with this, so I want to draw your attention back to some of the opening comments that you made with regard to answers with regard to the kind of -- the kind of condition of -- of the system and, you know, some of the comparisons to regulated utilities, but with a specific focus on reaction to some of the comments that were made this week on -- on how to improve our system as we move towards payment reform. How -- how -- how -- how -- what you would caution or recommend the Commonwealth or consider?

A. I would -- I would ask you to consider the following ideas, just a few, and let me just rattle them off.

First, I have now heard over and over and over again that 90 percent of the money collected by insurance companies is paid out for medical expenses and that, quote, only

10 percent is used for administrative costs. It appears to me that that 10 percent has remained constant over the years, notwithstanding a dramatic increase in overall medical costs. So that the 10 percent is not a constant. It's a growing number of dollars each year.

My experience dealing with other financial services industries, including insurance companies, is that they have over time been able to reduce their administrative costs as a percentage of total revenues because of improvements in data processing and in other -- the other transactional aspects of financial services industries. I would like to see the Commonwealth, through its Division of Insurance, investigate the question of why the 10 percent administrative cost component of the insurance companies seems to remain constant.

I've talked -- the second item, I've talked before about the power of the Commonwealth as a purchaser in influencing the direction of healthcare costs and the value that might inure to the population if the GIC, if Medicaid, if the Connector Authority were to evaluate experiments in which primary care doctors were paid better so that they could be more than triage doctors aligned with continued care and help reduce the use of specialists. I would suggest that.

The kind of transparency that you've presented in this hearing is very valuable. Frankly, it's a watershed. I think that should be continued, but I think it should be expanded to provide to the public, the legislator and regulators, transparency around particular commonly used medical procedures and to focus on the price charged to insurance companies, for example, by physicians in different networks for commonly used clinical procedures.

For example, what does a doctor get paid -- a GI doctor get paid for doing a colonoscopy, a regular colonoscopy, depending on whether that doctor is part of one network versus another network versus another network? The idea of doing that kind of thing would be to take these broad numbers and make them more tangible for the public and regulators and legislators to understand. Because the -- very often, you get the argument that one system or the other deserves higher rates because of whatever, higher quality, academic mission or whatever. Well, frankly, a colonoscopy is a colonoscopy is a colonoscopy, and I think it would be very powerful for the public to see that three community doctors providing service within two miles of one another in a given community in the western suburbs get a 30 or 40 percent difference in what they get paid for that. I think people -- I think that would end -- lend more moral authority to the moral authority you've already brought to the table.

I think I'd like to suggest that the Attorney General consider providing representation during the negotiating sessions between providers and insurance companies, to be in the room to watch what happens, to feel free to ask questions, not to take sides but just to watch what happens because the private meetings that take place, although termed "negotiating sessions," frankly, do not always feel like negotiating sessions.

The -- in -- in things I've written, I propose that we move to a formal rate setting process in Massachusetts, a la, Maryland or West Virginia. I understand there are objections to that. Short of a formal rate setting process, there is a role that could be set -- could be taken by the Commonwealth, perhaps through this very division, in producing benchmarks of appropriate reimbursement rates for different kinds of services, appropriate adders to -- by the way, this could take place under a global kind of approach or a fee-for-service approach -- appropriate adders for education programs, teaching programs offered by academic centers, appropriate adders for different population characteristics, different income levels of different part of the state and so on short of -- of -- of offering a formal rate setting process.

But to be an honest broker providing those kind of metrics or -- or ranges so that when the negotiations actually take place between providers and insurers, there's a standard out there that everybody could look at and say, if -- if the provider wanted more money or the insurer wanted to pay less money, at least somebody in the room could say, "But the division has come up with these benchmarks. Why should the rates we're talking about here in this particular negotiation be different from the benchmarks?" At least, then, you'll have a discussion, an explicit discussion about what might be countervailing factors or other factors that could come into play, because there very well could be. There is a complexity of this that rate setting doesn't always get at.

So I would offer that as a cascading set of things that the state could do. Review the insurance company administrative expense, act as a purchaser, as a more knowledgeable purchaser and influence the use of primary care, transparency, expanded transparency, have a government presence in the negotiating sessions, have benchmarks established by the division and then moving onto formal rate setting.

And then the final thing I would say is I think the state needs to take a more direct role as it -- perhaps not exactly in the way it used to before but in determination of need in terms of what services need to be provided by which hospitals.

I mentioned this yesterday in my testimony. Ellen Zane's hospital, my hospital, Boston Medical Center, Massachusetts General Hospital, Brigham & Women's Hospital, Lahey Clinic, U. Mass. Memorial, all provide solid organ transplants to the people of Massachusetts. There are not enough livers, kidneys and pancreas to justify all those programs.

Why do we do it? Well, we do it because our faculty, who are very expert and the like, feel it is an important part of their mission, their societal mission and their professional mission. Someone has to tell us no. It is not appropriate to do that.

The Brigham, for example, as I understand it, has begun to offer face transplant surgery. One of my doctors said, "We should do that, too," and I said, "I think society has enough facial face transplant services at the Brigham, and we don't need to create another one across the street." But that's the way these kinds of discussions happen and for those of us who are CEOs or department chiefs in these academic medical centers, we sometimes need to be told no, you can't do that, for very expensive procedures. We need to be told -- there's a case involving Lawrence General and Holy Family, who, for quite some time, have shared cardiac catheterization facilities. Recently, the Caritas Christi system decided to go off on its own and break apart that alliance. There's no economic or societal reason to do that. There may be a commercial reason for Caritas Christi to do that, but is society overall benefited by that? No.

We had a -- a linear accelerator in Waltham, which I offered to share with Newton-Wellesley Hospital rather than have them build a new facility because ours was under utilized. They chose not to do that because they wanted to, for commercial reasons, have their own facility. Examples like that happen over and over and over again, and I think the state needs to take a more active role in those determinations.

Q. I want to thank you for your testimony here today.

A. Thank you.

Q. That concludes my questions.

A. Thank you for having me.

Q. To the extent that there's anything supplementally you want to submit to the record, I understand from Commissioner Morales and his -- Athena Carrington that the record will remain open through this coming Friday and both you and others, if you wish to supplement once you review your questions, please do that by that timeframe.

A. Thank you for giving your time today. I appreciate it.

MR. O'BRIEN: If I could call Ms. Ann Ford.

Does our court reporter need a couple minutes?

(Off the record.)

MR. O'BRIEN: If we can go on record, and

I'll start that record with thanks to all the court reporters who have done the only work through this process. It's not easy to take these examinations, and this type of colloquy can be very, very difficult, so we appreciate the hard work that's gone into the hearing process.

For the examination -- the next examination of Ellen Zane, I would note for the record that she was sworn in earlier.

BY MR. O'BRIEN:

Q. Do you understand that you are still under oath?

A. I do.

Q. And the same kind of format that I followed with -- with Paul Levy as far as trying to analyze some of the -- some of the findings and some of the content of what has been presented through these hearings.

But I would start with the same place I did with Paul, which is please state your name and background and to the extent that earlier you indicated what capacity you were hear testifying on behalf of, please do so again.

A. My name is Ellen Zane, and I'm president and CEO of -- of Tufts Medical Center and the Floating Hospital for Children. And as I mentioned earlier, I am not here in the capacity as the chair of the Massachusetts Hospital Association, which I am serving in that capacity right now.

Prior to my appointment at Tufts in -- I came to Tufts in 2004. Prior to that, I was network president for Partners Healthcare System, founded by the Mass. General and Brigham & Women's Hospital, for ten years. And I believe that that perspective gives me a unique perspective for these hearings, given that I was involved with Partners from its inception in 1994 until 2004.

Prior to that, I was CEO of Quincy Hospital, which at the time was a municipally-owned public hospital managed by Hospital Corporation of America and Quorum Health Resources. So I worked for the for-profit enterprise out of Nashville Hospital Corporation of America when I managed Quincy

Hospital.

Q. That's an extensive and, obviously, impressive background of -- of experience in -- in medical care, and I think that some of the comments that -- during the panel that you participated in talked about the significant need to -- of -- of addressing the identified problems in the market, both through consumer approaches but also through provider approaches and in changing culture about where we're at.

And so now that you're being examined here, I'd ask whether you have some additional comments that flowed from your presentation and question and answer earlier with regard to those cultural shifts?

A. It was interesting to me when you asked about the cultural shifts that providers should engage in, because in my view I continue to believe that all roads lead to this gap, this pricing disparity that exists in the market.

And let me give you an example. In the Attorney General's report, it was noted that out of approximately the ten best reimbursed hospitals in the Commonwealth -- actually, I believe in the neighborhood of eight of them are community hospitals, not academic hospitals. And one of those community hospitals recently approached several of the obstetricians on my medical staff, offered them significant salary increases well above market where we believed participating in that bidding contest would have really warped the salary compensation of obstetricians in our region, and we chose not to participate in that and lost our most productive obstetricians to this very well reimbursed community hospital. And it is a very good example of what happens in the world of the haves and the have not's, because the haves used their additional reimbursement in order to compete against the have not's, if you will, those of us that are reimbursed below the median. So when we talk about the culture of how we interact with one another, that culture is unlikely to change unless we understand how to rectify and close the disparities gap that's associated with the market distortions that exist today.

Q. And one of the findings of the Attorney

General's report, and I'll -- I'm going to jump around to some extent, was on the higher compensated hospitals gaining market share, and Mr. Levy testified earlier that physician organizations and alignment of specialists are helping to drive that in part. Is that consistent with your experience and your example and otherwise?

A. It's consistent with my experience in general. What has happened as a result of significant differentials that are provided to certain providers in healthcare systems, that it begets the opportunity for them to enhance the number of physicians that work under their umbrella. That begets more market share and that begets more costs to the overall system. So we can see how the funneling of dollars disproportionately in one direction or another, ultimately, further works to warp the overall system balance.

Q. I think that the -- the examination this week, the hearings have been generally very supportive of both payment reform and the importance of integration of care. How -- how is integration of care, appropriate integration of care, different than something that might have a warping effect upon care?

A. Let me just step back for a moment and say that I agree with what Paul Levy said relative to the fact that global payments in and of themselves, more integration, and that is viewed in -- in the lingo we've talked about in these hearings, in and of themselves will not necessarily stop the warping behavior.

If I am a fee-for-service provider and I am a low-cost or a low-reimbursed and low-cost provider in a fee-for-service world, then I am going to have a lower trend in overall healthcare costs than a highly reimbursed high-cost global provider. In your report, the Attorney General's report clearly showed that that's the case.

So global payments in and of themselves are a mechanism to potentially better align providers all sitting at the table at the same time thinking about how to better provide more efficient and safer care. But unless we deal with the distortions in the market in and of themselves, those -- that type of reimbursement will do nothing to fix the underlying problems.

So it goes back to the fact that I keep saying over and over that all roads lead to understanding we have a system out of balance and that we have to do something in order to close that gap or we're going to continue to have the same problems we've been talking about for the last three days.

Q. If I could ask you to follow up that question and answer by addressing the -- the -- by separating from payment structure, the issue of appropriate integration of care. QCC has a -- issued a report that was produced with the Department of Public Health, "Work on Transitions in Care and the -- the Opportunities to Improve Health Through Integration." How is -- is -- is that integration and that kind of the alignment of -- of providers in a continuum different than payment reform?

A. Integration of providers where providers are under a -- a common tent, where they're working together at the same table, where they have aligned incentives to do the right thing is a very good thing, and we have number of examples of how that is existing in the market today. So all of us would agree that having a situation where it isn't about the doctors and the hospitals but it's about how a system of care talks about a population of patients and how to better improve the health status of that population is integration and is a better way of providing care.

As we said in this morning's panel, in order to develop the glue that keeps all of those providers together and helps them to communicate and operate as either a virtual or an absolute single enterprise is costly, and there are new costs associated with purchasing and putting in place that glue. But having said that, I think all of us believe that at the end of the day, rather than having disparate providers that are not glued together and that have no alignment of incentives and therefore are fragmenting care, that it's better for us to be in a system of care than not. Is that helpful?

Q. Yes. Yes, it's very helpful. As far as the -- I think that during the panel there were discussions of both some of the providers and what they've accomplished as far as integration and some of the platform necessary to manage both performance risk and some form of insurance risk, some form of risk contract, and the moderator actually mentioned about other states that actually had a kind of more centralized process around that platform for managing risk. Do you have a sense as to what the Commonwealth should do to either incent those who don't have the medical information structure or to -- to look at more system wide approaches to that -- that infrastructure development to -- to foster global payment structures?
A. First of all, let me say that I do not believe that there's a difference between insurance risk and performance risk. It's all risk. And when insurance companies choose to capitate providers, and that's typically, at the end of the day, what it is, they are moving the risk off of their balance sheets onto the balance

sheets of the providers. And the insurance companies at that moment absolutely know what their costs are going to be going forward. It is the provider at that point that does not. So as I often say publicly, it is hocus pocus, in my view, to say that there is such a thing as the separation of insurance risk and performance risk, because I fundamentally don't understand how that would operational-wise itself.

So in terms of whether or not the state should be helpful in getting everyone more ready to become more aligned, I think in our state, as we look across the Commonwealth, one size doesn't fit all. And there are parts of the Commonwealth where folks are absolutely ready for this and desirous of it, and then there are other parts where the infrastructure isn't even close. So I think we do have to look at providers who are ready and are able and are willing to try, and I think quite honestly, the development of relationships in Blue Cross's AQC contract is, in part, an example of providers who were willing to begin to go down that road. That's a non-traditional fee-for-service oriented road. But as Paul Levy said, the conditions of under which we do that have to be correct, because if they are not, it can have a devastating impact on the provider community involved.

Q. Now have -- has your medical center entered an AQC with Blue Cross?

A. Yes, we have, Tufts Medical Center has.

Q. And were there additional costs? And, again, I'm not looking for levels of detail that you wouldn't have with you, and this is not a 30(b)(6) looking to bind your medical center. This is just your information as an individual witness. Do you have some sense of cost or community structure changes that resulted from the acceptance of the AQC?

A. Yes, there are absolutely new costs associated. And I can't tell you off the top of my head exactly what they are, but it is as we discussed earlier. In order to succeed in an AQC or a capitated contract, one has to have excellence in data, and I want to go back to that in a moment, and one has to have the infrastructure that makes it so that the physicians and all the providers in the system have timely information so that we can make course corrections quickly if our medical spend is untoward. And the issue, historically, between health plans and providers has been the Holy Grail of data. It sounds like a pretty ho-hum concept, but the fact is it is the most valuable asset of a health plan, and the health plans know considerably more about how providers function than providers know about themselves.

So it is an incredibly dangerous thing for a provider system to take on risk like in an AQC contract if they are flying blind and they don't have very sophisticated real-time data about their performance. And any provider system that would acquiesce and take on that risk without that data is truly risking the long-term, even the short-term viability, of their system.

Q. Can you give us some examples of the kinds of data held by a health plan that allow or facilitate the management of risk by a provider?

A. It's largely claims data. That's -- that's basically what they have access to that providers don't.

So as a primary care physician submits a claim to a health plan and then the primary care physician sends the patient to a specialist in Timbuktu, and the specialist submits a claim into the health plan, and then the patient gets, perhaps, hospitalized, and then the patient goes to a long-term care facility or rehabilitation facility. As you can see, the claims information gets bigger and bigger and potentially very far a field of the original primary care provider who started the cascade to begin with.

The health plans have all that information, whether it's associated with the actual provision of the care, pharmaceutical utilization and all of the other ancillary utilization. Very important in order for us to understand whether the patients are in compliance with the healthcare treatment plan, and it's extremely important information for us to know whether or not the patients are seeking care as prescribed by the doctor.

Q. Is it -- is it -- is part of the result of the differences in information for your system a result of the fact that hospital-based care and certain types of care within -- within your structure and that other types of services that might take place for the patients who are served by your -- by your facility are served by other institutions which aren't part of the same entity?

A. The -- the real perverse part in all of that is the fact that in -- in Massachusetts, as we discussed in our panel earlier, patients have an appetite for a great deal of choice. And in their view, they have an insurance card and that -- that card tells them that they can have their gallbladder done at Cape Cod Hospital, at Brockton Hospital, at Tufts Medical Center or at the Mass. General, and they basically feel they can do what they want to do based on the fact that they've got an insurance card.

Couple that with the fact that the PPO market is growing and the HMO market is not.

So more and more patients have utter access -- unfettered access pretty much when they want it. So it is exceedingly difficult to integrate the care when patients believe they have a contract in their insurance card that tells them they can go in and out of systems of care whenever they feel like it.

And where I took exception to what our moderator said earlier today about the role of the patient is the fact that it's -- it puts the physicians in a position where the physicians have to play cop with the patients in order to say to the patients you should go left instead of right, and the patient looks up and says, "But my insurance contract promises me that I can go left instead of right." And I don't believe that physicians are cops. I believe physicians are advocates for their patients, and that's what they should be for their patients.

And I implore the business community and the consumers of the Commonwealth to work with us so that we're not set up to fail by giving consumers unfettered access and then turning around and saying to providers, "But you're providing too much care and it costs too much," when the consumers think they have the absolute right to that.

So I think it's important to understand that this is a multifaceted problem. It has to do with what the business community asks the health plans to design, what the health plans and the business community tell the consumers to expect, as well as the efficiency and efficacy of what providers provide.

Q. I expect you haven't reviewed all of the pre-trial testimony that's been filed in this matter.

A. A fair amount of it.

Q. A fair amount of it. I think -- because I think -- I'm going to -- I'm going to quote something and, obviously, you're not here to testify as to whether I'm quoting it correctly, but it was Atrius, in his pre-file testimony, he said the following: We believe that PPOs drive up costs and promote fragmentation of care. PPOs are designed to work in a fee-for-service environment that most would agree promotes unnecessary utilization of services. PPOs are not designed to work with global payments. To reduce costs trends without sacrificing quality and consumer access, consideration should be given to ways to decrease and restrict the prevalence of PPOs in the state.

Would you agree with that statement as I've read it?

A. I would largely agree with that statement as you've read it.

Perhaps a modification to a PPO product might be a requirement that there be a quarterback, that there be a primary care physician or primary care clinician that is mandating it as part of the PPO product. Today, by definition, it doesn't require that.

And I don't use deliberately, the word "gatekeeper." That's the old-fashioned terminology, because it's not about keeping people out of -- on the other side of the gate. It's about the advocate that navigates the care, the quarterback that orchestrates the care and that's only good. So it would seem to me that that statement is largely correct, but there could be some experimentation associated with the fact that if there is a primary care physician assigned, it would help a lot.

Q. And if I -- if I could kind of follow up on that assignment of a quarterback, to use your term, would he or she be restricted if they don't have information on the downstream costs associated with the provision of care that -- that their helping to direct?

A. I think -- could you repeat that.

Q. Sure. Sure. Let me -- let me rephrase it.

I think that earlier you said that excellent information on claims experiencing some of the downstream cost once a -- if recommendation is made by a physician. Is -- in a PPO structure where you had a quarterback, would that quarterback need to have the information of the downstream costs in order to effectively manage care?

A. I believe the quarterback would need that information, especially if there is any kind of risk involved. They absolutely, positively would need that information.

But in your earlier question you asked
about integration versus not being integrated
and if we're really talking about integrated
care, we need the data.
Q. And with regard to your -- your risk associated
with the AQC, are you at risk for the
downstream costs, if you could kind of explain
what is your risk and what isn't your risk
under the contract you have?
A. Largely, from a -- from a 10,000 foot -- yes,
we are. We -- we don't have 100 percent of the
risk but we have a significant amount of risk
such that people pay absolute attention, and if
at the end of the day there are huge deviations
from the quality metrics that are liberally
built into -- into that contract, then there
can be significant downside -- downside
outcomes for the medical center and its
physicians.
Q. And with regard to those -- to that product, is
that -- how much of your -- forgive my -- the
nomenclature, book of business with Blue Cross
is covered by the AQC?
A. About half, because the way -- as we looked at

our Blue Cross business, about 50 percent, perhaps a little more, was PPO, and about less than 50 percent was HMO, and the AQC covers the HMO population, not the PPO.

Q. Now, do you have in your PPO structure, primary care physicians within your -- within in your entity?

A. Within our what structure?

Q. To the extent that within the HMO structure, are the -- are primary care providers, whether, again, are nurse practitioners or physicians, are they part of your team?

A. Yes. I'm sorry, yes. Between the physicians that are part of the faculty practice plan, the academic physicians at the medical center and the community network called "NECWA" that we have, the primary care physicians in both of those buckets, if you will, are part of the AQC for the HMO patients.

Q. And are -- do some of those primary care providers also provide services on -- to PPO individuals?

A. Yes, almost all of them do.

Q. And do you receive similar information to help those "quarterbacks," to use your term, manage care at the same level for the PPO products as you receive for the HMO product?

A. I don't believe so, because they can't. The problem is, is consumers have no quarterbacks in a PPO. It's very fragmented. That -- the term from Atrius is correct. It's all over the place with no systemic way of -- of looking at it or controlling it. So there's no data -- there's no place to funnel it to and funnel it through.

Q. If -- if -- if the -- if the primary care physicians had access, your primary care providers on the PPO side, would that be beneficial to their ability to help as primary care providers, direct and help guide consumers, their patients in the process?

A. That's an important question. Because I believe that if physicians had the data, they absolutely would not discriminate in how they treat patients. If there's anything that most physicians dislike, it's two levels of care. Physicians pride themselves and view themselves as advocates for patients, and they want to

provide great care irrespective of the
insurance card.
So if they had the data, it would seem to
me that the excellence in the systems they
developed would migrate to all of the patients
that they provide for, if it's best in class
care.
Q. To the extent that it -- that through this
examination we found out that as far as the
networks of health maintenance organizations,
they're not limited. They have -- you have --
the network is complete, as complete as the PPO
networks.
A. Yes.
Q. What is the rational reason for only providing
that kind of quarterback level of information
on the HMO side and not on the PPO side, if you
know of a reason?
A. I don't know of the -- I don't know of the
reason, and it is unusual from an intellectual
point of view that our HMO networks here are as
complete as you say as the PPO networks. In
some cases, the premiums are actually higher
for the HMOs than they are for the PPOs. It

defies logic in a lot of respects, and I think it is virtually another example of how distorted this overall market is in its behavior.

So we need to think about what kind of products we should be providing, and how we should be providing them, and how we should be pricing them in order to make much more rational sense for the delivery of care in the market.

Q. To stay on the -- on the HMO side of the product divide, prior to the AQC and post AQC, is there a difference in the level of quality of the data you're receiving from Blue Cross?

A. Yes. The moment we signed the AQC contract, we got a significantly enhanced level of cooperation from the folks at Blue Cross relative to their willingness to provide data.

Now, I can't tell you chapter and verse, but the feedback I get from our team is that it hasn't been as forthcoming and as fast as had been suggested, but it has been of different -- a different level of cooperation over what was the case before.

And the theory behind it was that Blue Cross has more or less bet the farm on the AQC effort and that they want us as providers to succeed. And, quite honestly, we want to succeed in that product, and we want to show great outcomes, and we value the fact that we're a value provider. So all of us are aligned in that, and it makes sense for them to want to work with us, to give us the data so that we can all succeed. That's the rational part of it.

The irrational part of it is that sometimes in working with health plans, what seems to make sense for the market just doesn't seem to happen, so.

Q. So to the extent that there was another academic medical center that hasn't yet entered an AQC, your sense would be that -- that they -- that -- and, again, I'm not -- you know, this -- to the extent that this might be calling for speculation, feel free not to answer. It would be your expectation on that that they would not be receiving for their primary care providers, the same level of information to be patient advocates that your primary care providers are getting on one half of the product line, which is the HMO product line?

A. Based on my own experience, I would say that that would be a true statement. I can't speak for others, but based on my own experience that would be the situation.

Q. With regard to the -- the report, and so rather than walk me through, because I think there's been some -- a lot of interesting comments, I'm going to just read through the seven kind of major findings of the Attorney General's office. Then I'm going to go through some of the major findings of the division. To the extent that I'm leaving out some of the division's, you know, incredible work, I hope they will forgive me.

And I'll ask you two things. One, is what did Paul say that was wrong and if there was any thing --

A. Nothing.

Q. Nothing.

And then -- and then, what -- what, of

those findings you want to comment on?
A. Okay.
Q. So the findings, as -- as I would read through them, and I -- I might turn them into six, is that prices paid to insurers from -- by health insurers to hospitals and physicians aren't correlated to quality of care, sickness or acuity of the population, the percentage of Medicare, Medicaid or whether it's -- the facility is academic teaching or not. So that's one set.
Second, is that price variations are not adequately explained by differences in hospital costs. So that's two.
Three, is that they are correlated to leverage within the marketplace, three.
Four, that total medical expenses on a per member, per month basis isn't correlated to whether provider is fee for service or risk sharing in some way. So that's four.
Five, is that price increases more than utilization are a driver of current medical trend over the last few years.
And six, if I'm counting right, higher

priced hospitals are gaining market share, and seven, the commercial healthcare marketplace has been distorted by contracting purchased.

Of those seven, are there any -- I'll ask you first, are there any you disagree with based on your experience?

A. No.

Q. Okay.

A. I really like that chart over there, the one in the middle. Because as far as I'm concerned, it says it all.

Q. And that's the chart that shows that your CMI or the CMI for your organization --

A. Is the highest.

Q. -- your relative -- your relative payment rate, for at least that particular provider, and the differences in market leverage proxies that we -- we used on that is -- is less.

A. It -- that chart really summarizes the seven points you made, and says it really beautifully.

Q. I'll let who's ever behind bubble charts know that you're a fan of it.

As far as contracting practices, do you

have contracting practices that -- that restrict the ability of health insurers to innovate, whether it's participation requirements or?

A. Yes. There are contracting practices that are operative in this market that are restricting plans from the ability to innovate. Product participation agreements that don't allow for it, and they exist, are problematic, because it means that the health plans really can't go out there and do things like true limited networks. So product participation agreements are a problem.

There are -- there's a contracting practice about caps on health plans where health plans say they do not want providers to grow their networks of physicians and, therefore, they cap them in terms of how many doctors can come into the system. And in my own negotiations, I've scratched my head about that and I've said, "Let me understand this. If we, as a high quality, high case mix, low cost -- low-reimbursed provider are able to grow our network, then that means you as an insurer, a health plan, stand by what you represent to the business community by looking out for their interests in providing care more efficiently and more cost effectively. Why would you cap a provider who can help you do that?" And I have yet to get a sensible answer to that.

Now, in our own situation, we've been able to negotiate that to a -- to the ground where we needed to, but it is a contracting practice that is pervasive in this market. That is wrong, where there are games that are played with -- with some of the systems that are capped so that as many high cost and high-reimbursed providers as possible get in under those caps, and who benefits from that? Certainly not the business community, certainly not consumers. So that's another contracting practice that's a problem, and as you know, there's most favored nation clauses that are out there, too. So there are a number of contracting practices out there that absolutely inhibit innovation.

Q. To put a bit of a point on -- on that, there are, in the commercial marketplace, one -- one

health plan has more than 50 percent of the market and there are two other commercial health plans that have, also, significant market share, which is not -- as compared to the largest net, and those being Blue Cross, Tufts Health Plan and Harvard Pilgrim Health Care. Do you -- are these types of restrictive practices in place with -- with each of them?
A. I believe so.
Q. Going back to one of the other findings of the Attorney General's report with regard to total medical expenditures, do -- do you get, as part of the AQC information on total medical expenditures, is that what's being tracked in the context of -- of -- of the AQC contract?
A. Pretty much, yes. I couldn't give you chapter and verse on all the details, but the idea is to understand underneath the capitation arrangement that we are in, what our costs are and what the service provision is so that we can track against the expectation.
Q. And did you receive total medical expenditure and/or comparative total medical expenditure information in the past from Blue Cross?

A. No, not nearly as comprehensively, and what cause -- causes negotiations to become protracted is when one has difficulty getting historical comprehensive information so that you know what your base is when you negotiate to the future. If one doesn't know one's base activity, it's impossible to know what one should expect in the future and leads to the flying blind syndrome.

Q. Now I'm going to read through some of the -- what I -- what I've pulled from the division's reports as some of the key findings, and I just wanted to -- I'll lay them all out and ask you to comment on those that you either disagree with or -- or have no comments on.

First, the division's various reports noted that small group premiums grew faster than midsize and large but not by significant amounts. Small group premiums grew 5.8 percent on average. Large group at 5.4, and midsize at 4.8. So that's one finding.

Two, is that medical trend for 2006, 2008, was in total 15.5 percent.

Three, that outpatient services, including medical procedures, imaging and laboratory, which can be provided without an overnight stay, kind of grew as a percentage through hospital-based facilities, outpatient services.

And then two more that I'd -- I'd mention is that the way healthcare providers are paid rewards, those that provide a high number of individual services, as opposed to best coordinated. And the last one I'd just reference is that healthcare system is dominated by a high number of specialty doctors and -- our healthcare system by -- by a number -- high number of specialty doctors and academic and medical centers, and so I wanted to lay them all out to see whether a particular one of those that you disagree with based upon your experience?

A. So, could I pose upon you to go through them one at a time?

Q. Sure. I'll go through them one at a time. That -- that's fair.

A. Thank you.

Q. Starting with the -- the average growth of premiums, small group being at 5.8, slightly more than large group and midsize group, is that -- do you have information which would show that -- that would be consistent or inconsistent?

A. That would be -- because I would agree with what Paul Levy said, because I am not in the insurance side of the business, I can't basically say that. I know what I read in the paper, but -- but, personally, other than what I see happen for our own employees at Tufts Medical Center, I can't necessarily say that that's --

Q. And from your perspective, much like Beth Israel Deaconess's perspective, rates with health plans aren't set differently for small groups versus large?

A. Right. His -- his answer to that was absolutely correct. A gallbladder is a gallbladder, irrespective if whether it comes from the local florist shop or from Gillette. So the fact is that we're -- we negotiate rates, and I must say, parenthetically, that when I've heard the Mass. Association of Health Plans talk about the reason that small business premiums are as they are is because of provider cost, I -- I -- I really find that comment quite galling. Because the fact is we all know if we look at the real facts around that, that's -- that those small business premiums are designed around rate bands that have absolutely nothing to do with what any of us are paid for our gallbladders and that the gallbladders are the same irrespective of whether the patient comes from the local florist or -- or Gillette.

So the small business premiums and the hubbub that we're experiencing today about what to do for small business, I feel is misdirected, when we're not really looking at how small business premiums get built. And so I actually feel the -- the emotion and the visceral reaction about what's happening with small business is not consonant with the realty of how those premiums are made.

Q. The next was that they looked at growth trend from 2006 to 2008, from medical growth trend at 15.5 percent. Actually, termed it as "private spending per insured individual for

healthcare," to be more precise, at 15.5 percent. Is that consistent with what you see happening as far as medical trend based upon your experience?
A. Absolutely not. Because some of us are pooled in the have not category. I believe we have to be better managers, and we have had to work very hard in order to make sure that our medical -- that our cost trends are as flat as possible, and we have worked doubly hard. So whatever those premium trends are, they certainly aren't interpreting to the reimbursement that -- at least, we see, at Tufts Medical Center.
Q. The next that I've referenced for you is that outpatient services, including medical procedures, imaging and laboratory, which can be provided without an overnight stay in a hospital, their -- the growth and spending for care in outpatient hospitals was due in large part to growth in the prices and volume of imaging services, medical procedures and cancer therapies provided. Do you have a sense as to whether those --

A. So, I have an issue with the comments that have been made everywhere relative to utilization on the outpatient side, because it's my understanding that more research needs to be done on that relative to how we count outpatient procedures. And, although, I, again, can't cite chapter and verse, it's my understanding that over the last several years there have been changes in how units are -- are counted. So I'm not sure that those utilization increases, even though it's the smaller piece with the larger piece still being price, I'm not sure the utilization piece is correct.
Q. Have you seen in the marketplace, a shift towards outpatient facilities being -- or that type of care being aligned with hospitals as opposed to freestanding?
A. Yes. Yes. There are -- yes, in large part. We shouldn't forget, however, that a fair amount of outpatient activity takes place in physician offices that have their own imaging, their own gastroenterology suites and whatever, so it isn't insignificant. But we should be

asking ourselves the question irrespective of whether it's a hospital, outpatient setting or a physician or freestanding facility what -- what we're mitigating there, because it could be that we are offsetting an inpatient admission by doing that. So outpatient care de facto on the increase is not necessarily a bad thing.
Q. The next had to do with the way healthcare providers are paid rewards, high number of individual services and less coordination of care at -- in less expensive settings. Is that consistent with your experience?
A. On the -- on one side of it, we all say, "Gee, wouldn't it be better to move away from the piecemeal approach of fee for service. That rewards piecemeal activity." But, on the other side, if one reads your report, it shows that in cases where it wasn't fee for service, it didn't necessarily reduce cost. So it's unclear, I think, the answer for that.
Q. And then the last one that I'll reference with regard to the division's reports is that our healthcare system is dominated by a high number

of specialty doctors rather than primary care doctors and by academic medical centers, both which tend to provide costlier care.

A. Well, I, for one, at Tufts Medical Center say that that does not apply to us when there are eight community hospitals that are a whole lot more expensive than ours. And through serendipity, Tufts Medical Center is a small academic medical center, as compared with our friendly competitors. And it's turning out to be a very good thing, and it's why our case mix index is so high because we don't covet secondary care. We cover it. What we should covet is an academic medical center and that's high-end tertiary and ordinary care. So the fact that we have a lot of specialists is what we should have given our mission.

And while we are the community hospital, if you will, for the Chinatown community, for South Boston and -- and for the South End and for Dorchester, having said that, when we look at why our case mix index is as high as it is, it's because we -- our niche is tertiary and ordinary care.

Q. With that said, as far as your -- the volume of patients that you see for tertiary, ordinary care, are you disadvantaged by not having a broader provider network of specialists to refer to?

A. It -- it is important. As -- as Paul Levy said, "Academic medical centers, by their nature, really do see referrals to their facilities by community primary care physicians and specialists."

Our view is that we say to physicians, "You're the doctor. You decide what the most appropriate place is for the patient to receive care. If in your determination, the patient shouldn't receive the care locally because the specialty care is just not there, then we hope that we'll be viewed as a value provider where we are efficient and we are safe and we are high quality and we are lower cost."

So we think that we have a responsibility to be a value provider, but it's very important that we do have a network of both primary and specialty care physicians in the community that want to be in our orbit, if you will, because they are comfortable with the local care that they can provide and the tertiary and ordinary care as well.

Q. Paul, also, referenced some recommendations in -- with regard to further developing the primary care providers in our -- in our system that really turned on compensation structure and I guess valuing the services that -- that those providers provide. Do you -- do you agree with his perspective on that?

A. I do. Primary care physicians complain a lot, understandably, that their coordinating quarterback orchestrating role is really not valued to the degree that it should be and that there's a tremendous amount, that they call the "hassle factor" associated with their work, but there's one other point associated with that that I feel compelled to talk about, and that has to do with the Tufts University School of Medicine. Tufts University School of Medicine is one of America's great medical schools. And by -- by way of contrast, this past graduation, year ago May, Tufts University School of Medicine graduated 170 new physicians with one principle teaching hospital, Tufts Medical Center. By contrast, Harvard graduated 150 physicians with five principle teaching hospitals. So one can see that when a provider like Tufts Medical Center is starved from a reimbursement point of view, how not only that affects the survivability of a great medical center but how that can affect a great university and a great medical school. And therefore the pipeline of physicians to this area. By some -- by some quirk that the dean and I don't quite understand, there are more physicians that go to Tufts that happen to choose to remain and stay and practice in Eastern Massachusetts than is the case for most of the other medical schools, and for some reason Tufts graduates more physicians who choose to go into primary care. So if anything ever happens to that medical school or its medical center, then we have forever affected the pipeline of physicians to this region. So when we think about the issues surrounding primary care, it's more than about what they're being reimbursed. It's more than the hassle

factor. It's about the pipeline as well.
Q. When you say that there's more -- more primary care physicians out of Tufts Medical School, can you put that -- can you put some numbers on that for the most recent period of time, you know, if you -- if you have a sense as to how many primary care physicians are coming out of the Harvard program?
A. I can -- I can get that for you. I don't want to quote a number that I don't know, but the dean and I have talked about the fact that in terms of all the primary care specialties, Tufts trumps the other medical schools. In my own experience and my days at Pilgrim's, I can tell you that at Harvard, the number of physicians in primary care are very small. Also, by contrast, Tufts has a family practice program. Harvard does not.
Q. This -- we're getting to the close of the examination, and on a Friday afternoon, I'm sure lots of folks are happy to hear me say that, but I -- I also want to not in particular draw your attention to the five -- I think it was five recommendations that Paul had, but I

want to hear whether you have a list of recommendations --

A. I do.

Q. -- and things that we should consider?

I don't think that surprises us.

A. Yeah.

Q. I'd like to hear your recommendations, please.

A. One of the things I think we ought to be thinking about is how we standardize our fee schedules so that there's a normalized fee schedule for hospitals and doctors. That isn't to say that everybody gets paid the same thing.

What it is to say is the base upon which we make the decisions is based on a standardized definition over all providers, which can then have multipliers put on it for a variety of things, including the acuity of patients, including geography, accessibility, the standby capacity, the societal needs, in other words, that a provider provides.

But it would really be nice if there was transparency relative to a well known, well publicized, common definition of what a core set of reimbursement is for both hospitals and doctors. Right now, it is a complete black box with nobody willing to expose that and very little transparency on why. And we should know that even today, health plans have come to me and I'm sure to others and said, "Well, you know, we've got to make sure that all the doctors are on a similar fee schedule." They call it their "vanilla fee schedule." And, yeah, we occasionally need to give you more, but they give it in the term of these supplemental payments, which I always called "wheel barrels of cash" that come in the back door. So I think we need to stop that, and we need -- what we need to do is have a common structured fee schedule that everybody understands that gets built upon based on who you are, where you're located and what your mission is.

Q. Before you go on, I assume their might be some more recommendations, I know that the division actually looked at variation by DRG and put the average in and had useful information, and Paul had mentioned benchmarks and what -- and, you know, obviously, my healthcare options starts to get information out that gives kind of DRG specific -- DRG specific information. Is it -- is it a benchmarking? Is it taking that -- that unexplainable variation, I think is a fair way of putting what the division identified, and starting to squeeze it to say, you know, if you're off, you know, the standard deviation, up or down, you're really getting paid too little or too much. Let's start there.

A. Right. Right.

Q. And then start to converge, is that the --

A. Yes, yes. And I agree with what Paul said about this rush to the top is, I think, a fear but not necessarily a reality. Because just as you've said, there will be a -- there will be a rationale about why fees either go up or need to be red circled or come down. So I do think that standardizing this with a very under the sunlight definition of what these fees are is a good thing.

My second recommendation, I believe, is core to what we need to get the distortions out of this market, and it has to do with closing the gap between the haves and the have not's.

And when I say this, I always rush to say that I am not Robin Hood and I am not looking to be Robin Hood, and that at least those of us at Tufts Medical Center have no fear of having to earn our way and having to perform well.

However, the haves have had the benefit of additional reimbursement for many years, and that reimbursement has compounded year over year over year. Those of us that have not had that luxury are hardly able to reinvest in our facilities or prepare for global reimbursement or a new day, and we are eating our walls.

So we really have to take an honest look at what that gap is and help the quality, value providers to live long enough in order to remain viable in this market to fulfill exactly what this -- what this effort is trying to achieve, and that is to have quality, efficient providers at a reasonable cost.

And if we don't invest in those providers and close that gap to some degree, then we are putting at risk the fact that their balance sheets are weak because they have not been able to benefit from years of additional reimbursement.

Q. And if I -- if I might, and forgive me for jumping in again, but there are some providers who are double A rated?

A. Yes.

Q. And they are able to drawdown money for capital --

A. Uh-huh.

Q. -- at far less expensive rates than others.

And then there are some who simply can't -- can't drawdown the money to rebuild infrastructure.

A. Uh-huh.

Q. We have capacity issues in some of our vital urban centers, Lawrence is probably an example of it, Brockton, Holy Oak and others.

A. Uh-huh.

Q. Is there -- is there -- you know, beyond the curve and the disparities, is there -- are there ways in which the Commonwealth can help to facilitate necessary capital improvements in a more collective way than every tub and its own bottom, you know, eat your walls or not?

A. It's a very interesting idea. I haven't thought about it, but I do think a way to access capital in a way that's effective and not traditional would be very interesting for those of us that haven't got double A ratings and aren't going to see that because we haven't had the years of additional reimbursement.

So it would be an enormous help if the Commonwealth could really look at providers that need that in order to make sure that they are there tomorrow to help provide care for their communities.

Q. And part of the, I guess, if I might suggest it, arguments that might be that as a Commonwealth, it's -- you know, these not for profits.

A. Uh-huh.

Q. It's our capacity. We either pay you now or pay you later.

A. Well, there's a tremendous disruption in these communities if these hospitals just continue to get weaker, and that's essentially what's happening now. It's the old rich get richer and the poor get poorer, and it's dysfunctional relative to what it is we're trying to accomplish in care of these communities.

Lawrence General is probably a very good example of that, and the Commonwealth could play a role in that. I think it's a great idea.

Q. So standardization of fee schedules, closing the gap -- I stopped you after two again.

A. Yes. Right. Okay.

Q. Go on.

A. Limited network, we talked about that earlier today. I -- I do think that the time has come where folk are saying to themselves how much deeper am I going to dig? And if people don't want to pay double-digit increases in their premiums year over year, then we must all begin to make it clear there is a tradeoff. And if we can show that the quality tradeoff is not one of the tradeoffs they'd have to make and if there's support from the government and support from the health plans and support from the business community, we can do this. It's just been a shrugging of the shoulders in the past, with everybody says nobody wants this and everyone wants choice.

All things do change. We know nothing stays the same, and I believe that now is the time that the appetite for this could increase and we should try it. That's the next one.

The next one has to do with adequate payments from government, and I know that government is between a rock and a hard place right now. But the thing that I have found most interesting in listening to what's going on in these hearings is that while government has brought these hearings forward, government hasn't talked a lot about its role in the dysfunctionality of this market. And the fact is at the time of Chapter 58 in 2006, it was understood and in that legislation that the gap in Medicaid reimbursement had to improve, and at the time, I believe it was $.84 on the dollar with an aim to move it up to 95.

Today, at least at Tufts Medical Center, it's $.60 on the dollar and dropping, and for those of us like Tufts Medical Center that has 20, 21 percent Medicaid, not enough to be a dish hospital and three times more than the others -- the other academic medical centers in

Boston other than BMC, the fact is it just doesn't pencil. It's just simply not sustainable.

And all of the talk about cross subsidization from the commercial health plans, if you are not one of the leveraging providers, then you can't -- there's just no way that after the close of a negotiation you can go back to the Blue Cross's of the world and say, "By the way, here's another invoice for your fair share of the shortfall in Medicaid."

So I -- I have to say I think it's great in Massachusetts, we all do, that almost everybody here is covered in the Commonwealth. But let's really look at who paid for it. Who paid for it?

The government takes the credit for the fact that we have high accessibility and the coverage, but the providers are the ones who have taken it on the chin for that. So I think it's inappropriate to say it's all about the commercial health plans. It's all about the providers. Government needs to figure out a way, too, in all of this.

And I guess the next one would be another one where I agree with what Paul Levy said as well, relative to insurance administration and would encourage the state to look into that, again, as he said, this focus on providers being $.90 on the dollar and insurance plans only being $.10.

As a famous Bostonian says, "Nobody was ever cured in a health plan," and the fact is, every day I ask myself more and more, what is the value? Does a health plan need to have a billboard on the Expressway? What value does that bring? And because nobody was ever cured at a health plan, the real value they seem to bring is that they claims process and they sell.

But I have to ask myself all the time why are we paying 2 to 3 percent to brokers and why are we paying $.10 on the dollar when those premiums are getting bigger and bigger and there seems to be economy scale with their own infrastructures getting bigger and bigger?

So I think it's inappropriate that we've only said, "Gee, $.90 on the dollar is what we ought to be looking at because the rest of it is a measly $.10 cents." When I think there's a lot of opportunity in them there hills to solve the problems of the Commonwealth, including the Medicaid shortfalls, by taking a hard and transparent look at what's in those administrative fees, especially when some of it goes to risk reserves and that risk is being passed to the providers.

So the last one is transparency, which we've all talked about. It seems to me that what you have done is a tremendous service to the citizens of the Commonwealth by saying, "Now, that these are facts." It's no longer a discussion about what we think is going on, but what you all and the Department of Healthcare Finance and Policy have done is you have really shown effects, and I think there's nothing like a data-rich environment in order to make good decisions. So I congratulate you on that and say we need to have transparency on all phases of this.

Q. That concludes that answer and that concludes my questions, and I thank you for participating in the examination. And, again, I think Commissioner Morales I think, is going to come up and close for us.

MR. MORALES: Thank you, Assistant Attorney General Tom O'Brien, thank you, Ellen, thank you, Paul, for your candid responses.

We are going to conclude but before we do that, a couple of things. I just jotted some notes. While I'm not going to recap our hearings, I am going to say a couple of things.

The first thing is our goal, as we talked about for months, was to be sort of table setters, set a table for a discussion to have you, the stakeholders, discuss our research findings, discuss the real problems that we encountered on our research data, and explain to us, government, but also people, consumers, taxpayers, from your perspective, what some of those issues are and how we solve them. And I think we accomplished that, for the most part, one.

No. 2, to have an honest, public discussion that I don't think has happened yet on where we are in healthcare today, how it's impacting us and what we can do about it. I think we accomplished that also. So thank you all for that.

Next steps from here, the division, by law, as you know, is required to issue a final report, which we will do in the next three to four weeks, hopefully. That will be done with your input. We will work diligently on that as we've discussed, and then, hopefully, have some legislative action and regulatory actions in that report that we see come to fruition. That's our hope and we will definitely work hard to make sure that happens.

The sense of urgency could not be felt more. We've heard it from Senate President Murray, the governor. We've heard it from almost every panelist. The time to act is now. The biggest concerning point for me has been that every major economist that we've invited here has said the same thing, this trend cannot continue and so we know we have to take action.

Last but not least, I want to thank every single panelist that was here with us for the three days, the moderators, you in attendance. This could not have happened without some of the tremendous researchers we had along with us, so I want to thank them also publicly.

And then I also want to thank the Division of Insurance Commissioner Joe Murphy. John Auerbach was here on day one for the Department of Public Health and Commission of Public Health, and, of course, Tom O'Brien. Attorney General Martha Coakley, your team, unbelievable work and amazing partnership, I want to be very public about that. This has been a tremendous process for us, and last but not least, my team, who has done a tremendous job supporting us, supporting some of the great research, some of the great work, some of the great hearing work you saw today. I could not have done it without my team, so thank you all for that as well.

With that, I want to conclude our hearings. Thank you, again, and have a great weekend.

(Whereupon, the hearing was concluded at 4:55 p.m.)

C E R T I F I C A T E

I, Susan E. DiFraia, Certified Shorthand Reporter and Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that the foregoing transcript, Volume I, is a true and accurate transcription of my stenographic notes taken on March 19, 2010.

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Susan E. DiFraia

Notary Public

My commission expires 12/10/2011

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